

**A STUDY OF PATIENTS REFERRED FOLLOWING AN EPISODE OF  
SELF-HARM, A SUICIDE ATTEMPT, OR IN A SUICIDAL CRISIS USING  
ROUTINELY COLLECTED DATA**

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Professional Doctorate in Social Work (D60)

October 2014

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## **Abstract**

Self-harm and suicide prevention remain a priority of public health policy in the UK. Clinicians conducting psychosocial assessments in Accident and Emergency Departments are confronted with a complex and demanding task. There is a paucity of research into the content of psychosocial assessments and the experiences of clinicians conducting psychosocial assessments in Accident and Emergency Departments. This study examines the experiences of people who presented in an Accident and Emergency Department following self-harm or with suicidal ideation, as those are documented in the psychosocial assessments. Furthermore, the study explores the attitudes, feelings and experiences of clinicians working in a Psychiatric Liaison Team, as well as the process of making decisions about aftercare plans. In order to achieve this, qualitative methods were employed. A sample of sixty-one psychosocial assessments was collected and analysed using thematic analysis. The coding of the data was done inductively and deductively with the use of the categories of the Orbach and Mikulincer Mental Pain Scale. Two focus groups with clinicians were conducted and analysed with a grounded theory oriented approach. Stevens' framework was applied in order to analyse the interactional data in the focus groups. Key themes emerging from the focus groups were shared with service-users who offered their own interpretation of the data and findings.

The study draws on psychodynamic theories to explore the experiences of clinicians assessing and treating patients with self-harm and suicidal ideation in an Accident and Emergency Department and to make sense of the needs of the patients. The findings are that suicidal ideation and self-harm were assessed and treated in similar ways. Difficulties in relationships and experiences of loss or trauma in childhood and/or adulthood were the two most common themes emerging in the psychosocial assessments. Decisions about aftercare plans were guided by patients' presentation and needs in conjunction with available resources. Clinicians were found to have various emotional responses to patients' painful experiences with limited space to reflect upon these at work.

Clinicians and service-users commented upon the therapeutic aspect of psychosocial assessments, which in light of the painful experiences reported in the psychosocial assessments could be used to generate more sensitive and meaningful approaches to the care of this population. Providing support and a space for clinicians to be able to think of their task and their responses seems important.

## **Acknowledgments**

I would like to very much thank the clinicians and service-users who participated in the study as well as the Hospital that provided that data and the Mental Health Research Network. Throughout the study and writing, I have been grateful to Professor Stephen Briggs for his guidance and encouragement. I would also like to thank Dr Helen Hingley-Jones for the comments on the drafts of the thesis. I would like to especially acknowledge the help Dr Ioanna Vrouva, Ciaran Stuart and Dr Jesse Campbell offered with different aspects of the study.

## **Chapter 1- Self-harm & Suicidal Ideation: the context & literature**

### **1. Introduction & Overview**

Self-harm is considered to be a major public health issue and its prevention remains a priority of public health policy (Department of Health, 2002; 2009). Self-harm is strongly associated with eventual suicide (Hawton et al., 2003b; Kapur et al., 2005), and a wide range of mental illnesses such as depression, anxiety, personality disorders, schizophrenia (Hawton et al., 2013b; Singhal et al., 2014). The management of self-harm occurs within complex systems of health, social care and the voluntary sector.

This chapter will discuss the place of self-harm and suicidal ideation within the current diagnostic classification systems and their conceptual frameworks. The prevalence and contributory factors to self-harm and suicidal ideation will be outlined. The current practice of conducting psychosocial assessments in Accident & Emergency (A&E) Departments and its outcomes will be presented. Service-users' experiences of psychosocial assessments in A&E, and clinicians' attitudes will be discussed. This review will not attempt to present a final and definitive way of conceptualising self-harm and psychosocial assessments, but will attempt to discuss some key issues that contribute to an understanding of self-harm and psychosocial assessments conducted in A&E.

### **1.1.Diagnostic Classification & Concepts**

#### **i) Diagnostic Classification**

The tenth version of the International Classification of Diseases (ICD-10) (World Health Organisation; WHO, 1994) includes self-harm behaviour as a diagnostic criterion of borderline personality disorder. The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (American Psychiatric Association; APA, 2013) refers

to non-suicidal self-injury as a psychiatric disorder. The following diagnostic parameters are proposed:

*'A. In the last year, the individual has, on 5 or more days, engaged in intentional self-inflicted damage to the surface of his or her body, of a sort likely to induce bleeding or bruising or pain (for example, cutting, burning, stabbing, hitting, excessive rubbing).*

*B. The intentional injury is associated with at least 2 of the following:*

*1. Negative feelings or thoughts, such as depression, anxiety, tension, anger, generalized distress, or self-criticism.*

*2. Prior to engaging in the act, a period of preoccupation with the intended behaviour that is difficult to resist.*

*3. The urge to engage in self-injury occurs frequently.*

*4. The activity is engaged in with a purpose; this might be relief from a negative feeling/cognitive state or interpersonal difficulty or induction of a positive feeling state' (APA, 2013).*

Suicidal ideation does not constitute a diagnostic category within the current classification systems (APA, 2013; WHO, 1994); however, suicidal thoughts are considered as a symptom in some disorders, for instance, depression.

## **ii) Concepts & Definitions**

The term self-harm is being used widely in Europe to include all acts of intentional self-poisoning and self-injury, irrespective of motivation (Hawton et al, 2003a). This definition of self-harm was adopted by the NICE guidelines (2004; 2011). This is in recognition that suicidal intent is a dimensional phenomenon (Harriss et al., 2005) and that motivation for such behaviour is often complex (Hjelmeland et al., 2002). The term self-harm has been adopted in preference to deliberate self-harm by the Royal College of Psychiatrists (RCP) in response to concerns raised by service-users (Harriss et al., 2005).

A relatively recent concept analysis review revealed that there is agreement in the literature that self-harm is characterised by physical harm, which causes bodily pain (Toftthagen and Fagerstrøm, 2010). Sansone *et al.* (2000) defined torturing oneself with negative thoughts as constituting self-harm. Bulimia and starvation to death are regarded as means of self-harm by some writers (Haw et al, 2001; Poustie et al., 2004; Ruths et al., 2005; Sansone et al., 2000; Sansone et al., 2005). Hawton and van Heeringen (2009) choose the term 'attempted suicide' to recognise the high risk of suicide in people who self-harm. One potential complication with separating

self-harm and suicide attempt into two categories is that it is possible for self-injurious intent and suicidal intent to be present in the individual at the same time (Silverman et al., 2007b).

Suicidal ideation appears in the literature considerably less than self-harm. Suicidal ideation refers to thinking, considering or planning a suicide (Centre for Disease Control and Prevention, 2013). Some writers differentiate between suicidal thinking which they term suicidal ideation, and suicidal planning (Nock et al., 2008a). Spiers *et al.* (2014) suggest that suicidal ideation includes a feeling of tiredness of life, death wishes and thoughts of suicide.

In summary, various terms and definitions have been suggested to describe self-harm and suicidal ideation. Researchers have found that clinicians show very little agreement in their determination of who did and did not attempt suicide (Wagner et al., 2002). The lack of consensus in defining the complex phenomenon of self-harm and suicidal ideation can potentially result in difficulties in the communication between clinicians, researchers and policy makers, and to the study of the population at risk for suicide and self-harm (Silverman et al., 2007a; Kidd, 2003).

## **1.2.Epidemiology & Contributory Factors**

### **i) Epidemiological Parameters**

The exact prevalence of self-harm is unknown. Large-scale population surveys have suggested that 4.4% of individuals in the UK have harmed themselves previously (Kapur et al., 2009) and self-harm remains one of the commonest reasons for acute medical admission (Blunt et al., 2010). Acts of self-harm are generally more common in females (Bergen et al., 2010a; Gunnell et al., 2005; O'Loughlin et al., 2005). However, there is a variation in rates of self-harm by gender across life span. Whilst during the early years of adolescence, self-harm rates were far higher in females than males, self-harm in males increased markedly during the later teenage years through to the early 20's, peaking between 20 and 24 years (Hawton and Harriss, 2008). Kapur and Gask (2009) suggest that there has been a steady decrease in the female: male ratio; whereas formerly twice as many women as men harmed

themselves, currently the numbers are almost equal in many centres. The majority of cases (85%) involve self-poisoning, and paracetamol is ingested in 30–50% of these episodes (Kapur and Gask, 2009).

There are some suggestions of an increased incidence in certain ethnic groups; for example, women of South Asian origin (Bhui et al., 2007), people of Caribbean origin aged less than 35 years (McKenzie et al., 2003) and young Black African-Caribbean females (Cooper et al., 2010). A systematic review concluded that men and women with gay, lesbian, or bisexual orientation are more likely to self-harm than are heterosexuals (King et al., 2008). Nevertheless, considerable heterogeneity was noticed in this review.

Self-harm has been shown to be strongly associated with an increased risk of suicide, as approximately 25% of people who self-harm attempt suicide (Bilen et al., 2011; Cooper et al., 2005; Haw et al., 2007; Howson et al., 2008; Kendall et al., 2011). The population that self-harms has been found to have an overall increased mortality due to a wide range of causes (Hawton et al., 2006). Repetition of self-harm is also common (Kapur et al., 2006; Haw et al., 2007; Owens et al., 2002; Platt et al., 1988) and the relative risk of suicide in people who repeatedly self-harm is higher compared with the people who have a single self-harm episode (Haw et al., 2007; Zahl et al., 2004). Risk factors for repeated self-harm are self-injury as a method of self-harm, psychiatric treatment, alcohol and drug abuse, unemployment, marital status and female gender (Bilen et al., 2011; Colman et al., 2004; Okorie et al., 2011; Owens et al., 1994). It has been estimated that there are 220,000 self-harm presentations to general hospital each year (Hawton et al., 2007).

The prevalence of suicidal ideation seems to vary from study to study. Nock *et al.* (2008b) showed that the lifetime prevalence of suicidal ideation, and suicide plans, were 9.2%, and 3.1%, respectively, and that 60% of transitions from ideation to plan and attempt occur within the first year after the onset of ideation. While a cross-national study found that suicidal ideation increases sharply during adolescence and young adulthood (Nock et al., 2008b), a study in the UK found little evidence of trends in the prevalence of suicidal ideation, with the exception of women aged 44–50 years (Spiers et al., 2014). Suicidal ideation is considered to present a substantial risk factor for subsequent suicide attempts (Nock et al., 2008a).

## **ii) Contributory Factors**

Numerous factors contribute to self-harm and suicidal ideation. These can be categorised as distal (proximal dependent) and state (trait dependent) (Hawton and van Heeringen, 2009). People who self-harm have often been found to suffer from mental illnesses, most commonly depression, substance misuse, anxiety and personality disorders (Fliege et al., 2009; Hawton et al., 2013b; Krysinska et al., 2006; Singhal et al., 2014). Schizophrenia has also been found to be associated with self-harm (Harvey et al., 2008; Haw et al., 2005; Singhal et al., 2014). Perceived physical health problems and pain are risk factors for self-harm (Theodoulou et al., 2005). An increased risk of self-harm has been associated with epilepsy, asthma, migraine, psoriasis, diabetes mellitus, eczema, and inflammatory polyarthropathies (Singhal et al., 2014).

With regards to family factors, risk of self-harm is greater in the presence of parental mental illness, parental separation, early or prolonged separation from the parent, emotional neglect, and abuse, especially sexual abuse (Fliege et al., 2009; Lang et al., 2011). As for factors related to psychopathology, people who self-harm have been found to experience more frequent and more negative emotions in their lives than people who do not self-harm (Hawton and van Heeringen, 2009). They have been found to experience more difficulties in identifying or understanding their emotions than individuals who do not self-harm (Borrill et al., 2009; Paivio et al., 2004). Psychological dissociation (Batey et al., 2010) is a factor that correlates with self-harm (Batey et al., 2010; Klonsky, 2007). Despite many suggestions that self-injurers are impulsive, research on impulsivity in self-harm has yielded mixed results which may be related to the variety of ways impulsivity can be conceptualised and assessed (Glenn and Klonsky, 2010; McCloskey et al., 2012). In several studies, self-harm was associated with low self-esteem and difficulties with problem-solving (Fliege et al., 2009; Skegg, 2005). A positive association has been established between the way self-harm patients' perceive their problems and their expressions of hopelessness (Herrestad and Biong, 2010; McMillan et al., 2007; Milnes et al., 2002; O'Connor et al., 2008).

Adverse or stressful life events are thought to intensify the risk of self-harm. Self-harm has been associated with multiple life stressors; the most common being



difficulties in intimate relationships (Haw and Hawton, 2008). Risk of self-harm may be raised in unemployed people (Newman and Bland, 2007) and unemployment is a predictive factor of repeat self-harm (Johnston et al., 2006).

Finally, in keeping with studies investigating risk factors for suicide, it has been claimed that the media and the internet may encourage self-harming and may lead to contagion among users (Daine et al., 2013; Gunnell et al., 2012; Niedzwiedz, et al., 2014); nevertheless, the potential for those who use these websites to access positive experiences has been acknowledged (Daine et al., 2013). Availability of means for self-harm may contribute to someone acting on impulse (Skegg, 2005), and a number of initiatives has been taken in order to regulate the availability of means (Hawton et al., 2012).

Suicidal ideation has been found to be strongly associated with mental illness, primarily mood disorders (Marwaha et al., 2013; Singhal et al., 2014), impulse-control disorders, followed by anxiety disorders and substance use disorders (Nock et al., 2008a). Schizophrenia and suicidal ideation have also been found to correlate (Singhal et al., 2014). A psychological model of suicidal behaviour in schizophrenia, the Schematic Appraisals Model of Suicide (SAMS), argues that perceptions of defeat and entrapment are a core component of the psychological mechanisms underlying suicidal ideation in this group (Johnson et al., 2010). This model advocates that negative appraisals of events result in perceptions of defeat and entrapment in psychotic disorders and these in turn lead to suicidal ideation. This model has been supported by research findings (Johnson et al., 2010; Taylor et al., 2010).

As for social factors, Meltzer *et al.* (2011) studied the relationship between personal debt and suicidal ideation in the context of sociodemographic factors, such as employment and income, lifestyle behaviours, and recently experienced traumatic events. They found that the number of debts, source of the debt and reasons for debt are key correlates of suicidal ideation. The study concluded that unemployment, gambling, hazardous drinking, experiencing a financial crisis and having relationship breakdowns can contribute to debt, which in turn can increase the likelihood of suicidal ideation (Meltzer et al., 2011). The association between debt and suicidal ideation has been established in studies looking at the circumstances of those who

had died by suicide (Yip et al., 2007). Personal debt and house repossessions are likely to contribute to increased suicide rates in younger-age men whilst for men aged 35–44 years old job loss and long-term unemployment is considered to be a key risk factor for men aged 35-44 (Coope et al., 2014).

Associations between unemployment and suicidal ideation have been demonstrated in other studies (Gunnell et al., 2009; Haw et al., 2014; Legleye et al., 2010). Suicidal ideation in the homeless is considered to be 10 times more common than in the general population (Patterson and Holden, 2012). Lastly, in relation to social parameters, being unmarried or divorced (Nock et al., 2008a), and living alone (Legleye et al., 2010) have been related to suicidal ideation. Relative to other forms of stressors (for instance, financial), difficulties in interpersonal relationships are most consistently associated with suicidal ideation (Liu and Miller, 2014).

Physical and particularly sexual abuse during childhood is strongly associated with suicidal ideation (Bebbington et al., 2009; Brezo et al., 2008; Bruffaerts et al., 2010; Legleye et al., 2010; Miller et al., 2013) as well as domestic violence between parents (Afifi et al., 2008). In Legleye's study (2010), sexual abuse was a significant risk factor only in the female population. Severe sexual abuse seems to be associated with higher rates of suicide ideation and attempts, than are less severe sexual activities (Fergusson et al., 2008). Earlier onset of sexual abuse was associated with greater suicidal intent even after adjusting for other variables, such as personality disorders, age, and sex (Lopez-Castroman et al., 2013).

As for psychological factors, low self-esteem (deMan et al., 2002), and experiences of hopelessness (Lazary et al., 2012) are frequently cited parameters in the development of suicidal ideation. Gilbert and Allan (1998) proposed that feelings of being defeated and trapped in circumstances from which one feels that cannot escape result in depression and suicidal thinking. A systematic review confirmed this association (Taylor et al., 2011). Beck and colleagues (1974) suggest that the cognitive component of depression, labeled as hopelessness was the trigger for the development of suicidal ideation. Lester (2012) found that both the defeat-entrapment theory (Allan and Gilbert, 1998) and the hopelessness- helplessness theory (Beck et al., 1974) overlapped as both attempt to describe the mindset of the

suicidal person. He concluded that both constructs were similar in predicting suicidal behaviour.

Finally, poor self-perceived health (Goodwin and Marusic, 2011), physical pain and disability, for example multiple-sclerosis (Gaskill et al., 2011) have been described as risk factors for the development of suicidal ideation. There is an increase in the publication of studies examining the genetics of suicidal ideation and suicidal behaviour. Most of these studies focus on serotonergic genes, and some associations have been found between suicidal thinking and altered serotonergic function (van Heeringen and Mann, 2014).

In summary, a number of contributory factors have been identified for both for self-harm and suicidal ideation; some contributory factors are common for self-harm and suicidal ideation. It is likely that the causal pathways for self-harm and suicidal ideation are multifaceted. It is thought that self-harm and suicide may result from interactions between genes and environmental stressors (Hawton and van Heeringen, 2009).

### **iii) Self-harm & Suicidal ideation: are they different entities?**

Researchers are attempting to detect differences between people who experience self-harm thoughts and those who are actually self-harming. Two models have mainly been proposed and tested. The integrated motivational-volitional model of suicidal behaviour (O'Connor, 2011) argues that suicidal behaviour results from a complex interplay of factors. It posits that stressful life events that are appraised as being humiliating or defeating lead to feelings of entrapment which increase the risk of suicidal ideation. Whether suicidal ideation stems from entrapment is determined by a number of factors called motivational moderators namely limited social support, few positive thoughts for the future and dysfunctional goal regulation. Finally, the volitional factors are a group of parameters that increase the risk that an individual will act upon the suicidal thoughts. They include impulsivity, access to means and exposure to others who have attempted suicide. Whilst this model was developed with suicidality in mind, it is considered to be applicable to self-harm. This model was applied to an adolescent population (O'Connor et al., 2012) and relative to ideators, adolescents who self-harmed were more likely to have a family member/ friend who

had self-harmed, more likely to think that their peers were engaging in self-harm and they were more impulsive than those with suicidal ideation. Adolescents who self-harmed reported slightly more life stressors compared to adolescents with suicidal thoughts.

This model was tested on adult population but no significant differences between the two groups were identified (Kirtley et al., 2012). No research has been published on the applicability of this model in adults. Joiner *et al.* (2009) propose the interpersonal-psychological theory of suicide and argue that 'thwarted belongingness' and 'perceived burdensomeness' lead to suicidal ideation/desire, and the desire is not translated into suicidal act unless the capability for suicide is present. From an epidemiological perspective, whilst depression may predict suicidal ideation but not plans or attempts, disorders that are characterised by severe anxiety, agitation and poor impulse control may be associated with suicidal plans and attempts (Nock et al., 2010). A study found that factors differentiating those who attempt suicide from ideators involve being unemployed, physical ill health and relationship difficulties (Fairweather et al., 2006). Traumatic events have not been found to predict the transition for suicidal ideation to suicide in adults (Stein et al., 2010).

### **1.3.Psychosocial Assessments in Accident & Emergency Departments**

#### **i) Overview**

Guidelines have been published (NICE, 2004; RCP, 2010) recommending that all patients attending A&E Departments with self-harm should be offered a psychosocial assessment. The NICE guidelines (2004; 2011) describe a psychosocial assessment, as an evaluation of the social, psychological and motivational factors specific to the act of self-harm, suicidal intent and hopelessness, as well as a full mental health and social needs assessment. A review concluded that the guidelines fail to clarify at what stage the assessment should occur, who should perform the assessment, and which precise elements the assessment should contain, and

therefore, further direction is needed (Pitman and Tyrer, 2008). Clinicians working in Psychiatric Liaison Teams usually undertake psychosocial assessments.

There is wide variation in practice between hospitals, and some studies found that many patients left emergency departments without receiving a psychosocial assessment (Barr et al., 2005; Bennewith et al., 2004; Bennewith et al., 2005; Gunnell et al., 2005; Haw et al., 2003; Hickey et al., 2001; Horrocks et al., 2003; Hughes & Kosky, 2007; Jones and Avies-Jones, 2007; Kapur et al., 1998; Kapur et al., 2004; Kapur et al., 2008; Kapur et al., 2013; Mullins et al., 2010). A recent study found that the majority of people presenting with self-harm were offered a psychosocial assessment by specialist psychiatric staff (Bergen et al., 2010b).

Factors associated with the non-assessment of self-harm patients vary including patients discharging themselves, patients discharged by hospital staff, being male, taking illegal drugs/alcohol, attendance out of office hours and young age (Bennewith et al., 2005). Crowder *et al.* (2004) studied 50 premature self-discharges and compared them to patients who received psychosocial assessments. The patients who discharged themselves without a psychosocial assessment were found to be more likely to have presented with self-poisoning in the absence of alcohol and to have no identified history of self-harm. Another study found that non-assessed patients were more likely to have a history of self-harm, to be in the 20-34 year age group, and to have displayed aggressive behaviour in A&E (Hickey et al., 2001). Mullins *et al.* (2010) indicated that single male patients with a psychiatric illness and a history of self-harm were less likely to receive a psychosocial assessment. Patients presenting outside working hours (8:00- 17:00) have been found to be less likely to receive a psychosocial assessment (Bergen and Hawton, 2007; Hickey et al., 2001). Other studies (Kapur et al., 2003; Mullins et al., 2010) did not confirm this finding.

Various studies have investigated the outcomes of psychosocial assessments following an A&E presentation with an episode of self-harm (Barr et al., 2005; Brakoulias et al., 2006; Cooper et al., 2010; Haw et al., 2003; Horrocks et al., 2003; Kapur et al., 1998; Ruths et al., 2005). Referral to the GP and referral to community mental health services were the two most likely aftercare treatments offered (Barr et al., 2005; Cooper et al., 2010; Horrocks et al., 2003; Kapur et al., 1998; Mullins et al.,

2010; Wittouck et al., 2010). Admission to a psychiatric ward and referral to mental health services were the most likely aftercare arrangements for patients referred with self-harm to a specialist liaison team in Australia (Brakoulas et al., 2006). Two studies concerned with self-harm in the elderly (Marriott et al., 2003; Ruths et al., 2005) found that the majority of the patients received psychosocial assessments in A&E Departments and aftercare by community services; however, the treatments or services offered were not specified. Wittouck *et al.* (2010) found that most patients complied with the aftercare treatment plan made following a standardised psychosocial assessment.

As previously discussed, psychosocial assessments are closely related to treatments offered and have been found to improve access to aftercare (Barr et al., 2005; Kapur et al., 2005). Differences have been identified with regards to the aftercare arrangements made by nurses compared to doctors. Greater use of statutory aftercare arrangements by psychiatrists than nurses has been demonstrated, particularly in relation to psychiatric admission (Russell and Mitchell, 2000; Russell and Owens, 2010; Weston, 2003), and referral to statutory community services for follow-up (Whyte and Blewett, 2001; Weston, 2003). Conversely, nurses are more likely than psychiatrists to refer a patient back to the primary care team without arranging additional follow up (Griffin and Bisson, 2001; Russell and Owens, 2010; Weston, 2003). Russell and Owens (2010) found that nurses were more likely to direct patients to services provided by the voluntary sector. Murphy *et al.* (2011) identified striking similarities in the factors that both nurses and psychiatrists identified as risks. However, psychiatrists were found to be much more likely to admit patients following identification of high risk.

The value of psychosocial assessments with regards to repeat self-harm has been found to be equivocal. Whilst, some studies have found that repetition rates are lower for people who are assessed (Bergen et al., 2010b; Crawford et al., 1998; Hickey et al., 2001; Jonhston et al., 2006; Kapur et al., 2002; Kapur et al., 2006; Kapur et al., 2013), two studies have found no significant difference in the rates of repetition (Barr et al., 2005; Kapur et al., 2008). A recent review has failed to find a protective association between psychosocial assessment and risk of repeat self-harm (Carroll et al., 2014). The presence of a psychosocial assessment did not

appear to influence the rate of repetition but being referred for specialist follow up further to the assessment was (Kapur et al., 2004). Another study found very little evidence to support this (Kapur et al., 2013). Kapur *et al.* (2013) found that the association between psychosocial assessment and a reduced risk of repeat self-harm appeared to be least evident in patients from very deprived areas. Repetition of self-harm has been found to be equally common among those assessed by nurses or psychiatrists (Russell and Owens, 2010). The methodology in the aforementioned studies and the population being studied vary considerably which may be related to some extent to the equivocal outcomes.

Whilst, a number of parameters related to psychosocial assessments have been studied systematically, the content of the psychosocial assessments is not thoroughly described in any of the studies and thus, variations may also exist in the type of assessment offered. In fact, little is known about the content of psychosocial assessments carried out in A&E Departments, which constitutes a gap in the existing self-harm literature. A different study design, for instance a sufficiently powered multi-centred randomised controlled trial would be more likely to identify the potential benefits of psychosocial assessments for the patients who self-harm, attempt suicide or experience suicidal ideation. However, this is bound to have serious ethical implications.

## **ii) Patients' Experiences of Psychosocial Assessments**

A systematic review concluded that despite variations in health care systems and settings, patients' experiences were characterised by poor communication between patients and staff, and a perceived lack of staff knowledge in relation to self-harm (Taylor et al., 2009). Overall, patients seem to experience the initial and physical care received in A&E as hostile and unresponsive to their mental health needs (Brophy et al., 2006; Horrocks et al., 2005). Few studies have been undertaken to explore how patients with self-harm and/or suicidal ideation experience the psychosocial assessments delivered in A&E by specialist psychiatric liaison/self-harm teams (see Appendix A.1 for a summary of the studies). It is acknowledged that patients' experiences are often studied by qualitative methods and searching for published qualitative research using electronic databases is regarded to be of limited

value due to poor indexing and absence of abstracts for many qualitative studies (Dixon-Woods et al., 2006; Dixon-Wood et al., 2007).

The experiences of patients who have received a psychosocial assessment in A&E vary. A study in the Netherlands evaluated 120 assessments (consultations) with patients referred following an attempted suicide (Hengeveld et al., 1988). Interviews with patients, consisting of open and closed questions indicated that one quarter to half of the patients were negative or not satisfied with the assessment carried out by psychiatrists. The patients described the psychiatrists as rejecting, arrogant, hostile, irritated, blunt or patronising. The group of patients, who had a previous admission due to an attempted suicide, strongly felt that not enough time, was devoted to the assessment. The content of the psychosocial assessment offered to these patients is fairly unclear in this paper. The sample frame is well defined in this study. A validated scale was not used and it was not described how the open-ended questions were analysed.

In an attempt to examine the experiences of services users, the NICE guidelines (2004) held two focus groups and an individual interview with a service-user. Participants were asked to comment on their experiences of care in the first 48 hours after an episode of self-harm primarily, including General Practitioners (GP), and A&E. Service users were found to have both positive and negative experiences. Their negative experiences were primarily associated with the negative attitudes of the staff offering initial and physical care. They wished to be given the opportunity to talk about why they self-harmed during the process of the psychosocial assessment. Some participants of the focus groups raised concerns about how the clinicians determined the need for aftercare and reported that being unable to get 'appropriate' referrals was stressful. They highlighted that being referred to another service, without having the process explained to them resulted in a negative experience. The process by which the researchers analysed the data collected during the focus groups was not described.

A qualitative study using interviews with 45 service-users found that the patients experienced psychosocial assessment as another procedure and felt that they were not listened to (Horrocks et al., 2005). Lack of empathy and lack of expertise were also reported. Nevertheless, some respondents described staff as



responsive and understanding. This study found that some patients did not feel able to engage with the clinician in the psychosocial assessment as the physical space was often invaded by other staff members. The study found that discharge following psychosocial assessments was difficult for service-users who did not feel ready to leave the A&E Department, for either physical or psychological reasons. Feelings of disorientation and abandonment were reported as prevailing themes. Delays in follow-ups by community services were often reported which of course is beyond the control of A&E clinicians. It emerged that although clinicians were often providing information about community services (primarily voluntary services) during the psychosocial assessment, the patients did not feel able to make contact with those services. Limited and arbitrary information provided in relation to how the data were analysed.

An audit of the RCP revealed that positive experiences were described by patients who were provided with an opportunity to talk about their difficulties and feelings (Palmer *et al.*, 2006). Patients valued to be given the opportunity to understand the goals of the assessment and to be involved in the treatment decisions (Palmer *et al.*, 2006). Nevertheless, the same audit revealed that a considerable number of patients reported that staff held negative attitudes (Palmer *et al.*, 2007). In this audit, a third of service-users reported that they avoid attending A&E Departments following self-harm due to previous negative experiences. In keeping with the previous study, Palmer *et al.* (2007) found that 57% of their respondents felt that they were not offered the appropriate aftercare.

Lastly, Hunter *et al.* (2013) studied the impact of psychosocial assessment over time utilising interpretative phenomenological analysis. Thirteen patients participated in this study, which identified both positive and negative experiences. Interviews were conducted after the index episode and for a subsample of the participants follow-up interviews were conducted three months after initial interview. They found that psychosocial assessment had the potential to instil or hinder hope, dependent on whether it was experienced as accepting or judgmental. Participants whose social circumstances were contributing to their distress, valued a psychosocial assessment and aftercare plan that addressed both their psychological and social needs. Finally,

the study identified that few participants had understood the purpose of a psychosocial assessment.

Some published studies identifying difficulties in the way patients felt they were perceived and treated by professionals; however, it is very unclear whether these were related to patients' experiences of A&E psychosocial assessment (Hopkins et al., 2002; Lindgren et al., 2004; Smith et al., 2002; Warm et al., 2002). Therefore, these findings are not discussed here.

In conclusion, it seems that the limited available evidence suggest that service-users report both positive and negative experiences of the assessment process and the attitudes of staff. Nevertheless, there is an emphasis on negative experiences related both to the assessment process but also the care plans made following the assessment. This is of critical importance as perceived feelings of rejection and hostility in people who have suicidal thoughts may lead to further self-harm or suicide attempts (Slaven et al., 2002). The therapeutic value of the psychosocial assessment for adolescents presenting with self-harm is well acknowledged and a Therapeutic Assessment (TA) has been devised (Ougrin et al., 2011). TA has been found to be associated with significant improvement in engagement with services further to the self-harm episode (Ougrin et al., 2011). However, it has not been associated with a lower frequency of A&E self-harm presentations (Ougrin et al., 2013).

#### **1.4. Attitudes of Clinical Staff**

Simpson (2006) suggests that nurses' attitudes can interfere with following the NICE guidelines. It is suggested that a supportive and caring attitude by clinicians in the A&E Department may encourage some patients who are prone to leave before their assessment is completed to remain in A&E (Barr et al., 2005). Eagley and Chaiken (1998) define attitude as a psychological tendency that is expressed by evaluating a particular entity with some degree of favour or disfavour. Fazio (2007) defines attitude as an association in memory between a given object and a given summary evaluation of the object. Despite the many definitions of the concept, there is

agreement that attitudes imply evaluation and are concerned with how people feel about an issue (Simmons, 2001).

There is a strong relationship between attitudes and behaviour (Bennett and Murphy, 1997) due to the fact that attitudes may influence behaviour and, in turn, be influenced by it. Oppenheim (1992) suggests that attitudes are reinforced by beliefs and often attract strong feelings, which may result to particular behaviours. Attitudes are also thought to influence information processing (Maio and Haddock, 2010). The formation of attitudes has been the subject of study for many years and various models of various theoretical orientations have been suggested. Maio and Haddock (2010) suggest that cognitive, affective and behavioural influences shape attitudes. Attitudes are not considered to be fixed and inflexible. According to social learning theory attitudes change as people learn to associate the attitude object with pleasant or unpleasant contexts or consequences (Bohner, 2001). They are measured quantitatively and qualitatively. Various scales have been devised in order to measure clinicians' towards suicide (Kodaka et al., 2011) (see Appendix A.2 for the most frequently used scales).

There is evidence to suggest that people who self-harm encounter negative attitudes when assessed and treated by health professionals (for reviews, Michael and Felton, 2010; NICE, 2004; Pompili et al., 2005; Saunders et al., 2012; for additional studies not included in the review, Botega et al., 2005; McElroy and Sheppard, 1999; McKinlay et al., 2001; Slaven and Kisely, 2002; Wheatley and Austin-Payne, 2009). A systematic review (Saunders et al., 2012) concluded that psychiatric staff in community and hospital settings were found to display more positive attitudes than general hospital staff.

A number of factors influencing attitudes has been identified namely, the self-inflicting nature of harm, means of self-harm, repeat self-harm, the averseness of some injuries, and the gender, work experience and professional discipline of care staff (Martin and Chapman, 2014; Michael and Felton, 2010; Pompili et al., 2005). Conclusions are tentative as no consensus has been reached with regards to the parameters that influence professionals' attitudes. In addition, emergency department medical staff has been found to hold positive attitudes towards self-harm in some studies (Martin and Chapman, 2014; McCann et al., 2006; McCarthy and

Gijbels, 2010; Suominen et al., 2007; Sun et al., 2007). A study found that medical A&E staff experienced mixed emotions when caring for this group, including anger and frustration (Chapman and Martin, 2014). Lack of confidence in working with this population and education has been highlighted in all reviews (Michael and Felton, 2010; NICE, 2004; Pompili et al., 2004).

Only eight studies appeared to have focused on the attitudes of specialist psychiatric staff undertaking assessments of self-harm or suicide attempts in A&E Departments (Gibb et al., 2010; Platt and Salter, 1987; RCP, 2010; Redley, 2009; Samuelsson et al., 1997a; Samuelsson et al., 1997b; Suokas et al., 2008; Suokas et al., 2009) (see Appendix A.3 for a summary of the studies).

In relation to the aims of the eight studies, half of the studies examined attitudes towards patients who had an episode of self-harm (Gibb et al., 2010; Platt and Salter, 1987; RCP, 2010; Redley, 2010) and the rest examined attitudes towards patients who had attempted suicide (Samuelsson et al., 1997a; Samuelsson et al., 1997b; Suokas et al., 2008; Suokas et al., 2009). The sample and methodology of the eight studies differ remarkably. Only three studies were conducted in the UK (Platt and Salter, 1987; RCP, 2010; Redley, 2009). As for the methodology, seven studies employed quantitative methodologies to explore attitudes using questionnaires. However, only four studies referred to the psychometric properties of the scales used (Samuelsson et al., 1997a; Samuelsson et al., 1997b; Suokas et al., 2008; Suokas et al., 2009).

Suokas *et al.* (2008) and Suokas *et al.* (2009) showed that clinicians viewed positively and sympathetically patients who presented with a suicide attempt in A&E in Hospitals in Finland. Gibb (2010), with a similar study design, found a mixture of positive and negative attitudes; nevertheless, the clinicians thought that their contact with patients was meaningful. Four studies (Gibb et al., 2010; Platt and Salter, 1987; Samuelsson et al., 1997b; Suokas et al., 2008) explored differences in attitudes held between clinicians in specialist psychiatric teams; however, the findings are not consistent. Whilst two studies indicated that psychiatric staff expressed more positive attitudes compared to those working in general medicine; other studies showed no notable difference (Gibb et al., 2010; Platt and Salter, 1987). Samuelsson *et al.* (1997a) investigated the attitudes of clinicians in different

departments of a psychiatric hospital and concluded that nurses in the A&E Department held more positive attitudes compared to their colleagues in other departments. Although one study found some associations between attitudes and personal characteristics (gender and age) (Samuelsson et al., 1997a), this was not found to be the case in another study (Gibb et al., 2010).

Training was a theme that emerged in three studies. Whereas psychiatrists working in specialist teams considered that they had sufficient training (RCP, 2010), this did not seem to be the case for clinicians working in General hospital departments (Gibb et al., 2010; Samuelsson et al., 1997b). Difficulties in the discharge process and difficulties with arranging admission to psychiatric inpatient wards were revealed in one survey (RCP, 2010). The difficulty in treating patients who repeatedly presented in A&E emerged in one study (Gibb et al., 2010).

The only study that employed solely a qualitative method demonstrated that clinicians did not routinely explore patient's reasons for taking an overdose as a refuge from the possibility of being overwhelmed by the emotional difficulties of patients who often also face social and economic problems (Redley, 2010). From a different but related angle, Gibb *et al.* (2010) found that clinicians lack confidence in working with individuals who self-harm.

It is suggested that mental health practitioners and doctors are disorientated in relationship to suicidal patients primarily because suicide is the event most alien to the nature of medicine as suicidal patients often attempt to defeat the doctor and try self-annihilation processes (Pompili et al., 2005). The findings from the previously described studies do not seem to entirely confirm this. It is very difficult to draw firm conclusions; however, there is a difference in relation to what patients report about clinicians' attitudes and what emerged in the eight studies that were reviewed. This may be attributed to a number of factors and to some extent, it could be associated with patients' experiences of the initial and physical care received in A&E Departments which have been shown from their accounts and the literature to often be a traumatic experience. On the other hand, a hopeless or aggressive patient who presents in A&E following self-harm or a suicide attempt may evoke in the clinicians negative attitudes, such as anxiety, anger, and an absence of empathy (Alston and Robinson, 1992). Although these feelings may be unconscious or not expressed

verbally, patients may sense rejection through clinicians' demeanor and manner. A review suggests that there is little shared understanding about self-harm between patients and professionals or between professionals themselves (Bosman and van Meijel, 2008). Finally, some studies were carried out overseas and therefore, differences may exist in how services are organised, resourced and run.

Research in this field has employed different methodologies. The majority of scales used across the studies of health professionals' attitudes towards self-harm have shown limited evidence of good psychometric properties which may have implications for the outcomes. Attitudes and suicidal related behaviours were not clearly defined across the studies which add to the confusion particularly given that attitude is a multi-dimensional phenomenon. Hence, it is difficult to make comparisons of one study with another. Considering that differences seem to occur between attitudes toward self-poisoning and self-injury, it may be that the lethality of self-harm and suicide attempts is a parameter influencing clinicians' feelings and ways of relating to patients which was not explored in any of the studies. Lastly, with the exception of the study undertaken by Redley (2010), no other research team positioned themselves in relation to a theoretical framework.

Some studies have regrettably failed to explicitly define their sample and hence, they are not discussed in this chapter (Huband and Tantam, 2000; Patterson et al., 2007a; Patterson et al., 2007b; Suominen et al., 2007).

To conclude, despite the ample of research on attitudes and its limitations, it appears that the attitudes and experiences of clinicians in A&E Psychiatric Liaison Teams have not been explored thoroughly. Most studies on attitudes towards self-harm or suicide focus on the attitudes of individual clinicians. It is, therefore, unclear to what extent the attitudes of individuals may be reflected in a team's culture and overall attitude. Finally, although a psychosocial assessment may be therapeutic in its own right (NICE, 2004), there is limited knowledge about the experiences of clinicians who carry out psychosocial assessments in A&E Departments, and their thinking process in devising care plans.

### **1.5. Psychiatric Liaison Teams**

As discussed A&E Departments play an important role in the management of self-harm, with self-harm presentations being reported as one of the five most common causes of acute medical admission in the UK (Health and Social Care Information Centre, 2014). Therefore, bridging the gap between physical and mental health care is essential (Plumridge and Reid, 2012). Liaison psychiatry is concerned with the management of psychiatric illness in general medical settings (Sharpe, 2014). Psychiatric Liaison Teams work with patients in general hospitals who require psychological help including 1) older people suffering from dementia 2) individuals who self-harm, experience suicidal ideation or are psychotic, and are being seen in A&E 3) people with mental health problems who are currently in hospital with a physical illness 4) patients diagnosed with a physical illness who need emotional support to adjust to this (Linnington et al., 2012).

Self-harm is the main reason for A&E referrals to Psychiatric Liaison Teams (Parsonage et al., 2012). This is thought to be driven in part by the NICE guidelines (2004; 2011) which recommend that all patients who self-harm should receive a full psychosocial assessment. The psychosocial assessments carried out by Psychiatric Liaison Teams are followed by management plans for follow-up care. There are different models of liaison psychiatry (Tadros et al., 2013); however, it is suggested that all teams should be multi-disciplinary in composition (Parsonage et al., 2012). Some general hospitals appear to have little provision of organised mental health support with mental health staff visiting the hospitals, while others have large in-house specialist teams (Parsonage et al., 2012). The availability of these services in general hospitals seems to have expanded considerably in recent years, in line with guidance produced by the Royal College of Psychiatrists (2004), the Department of Health (2011) and NICE (2004).

Psychosocial assessments are offered rapidly upon a patients' presentation in A&E and following medical assessment. The significance of psychosocial assessments has been described in a former section (1.3). It is suggested that patients occupying A&E hospital beds waiting to be assessed by psychiatric services is not only an example of financial waste, but it also increases dissatisfaction for both patients and staff, which in turn leads to poor outcomes (Tadros et al., 2013). There

is evidence that some Psychiatric Liaison services are cost-effective and reduce the length of stay when involved early (Parsonage and Fossey, 2011; Wood and Wand, 2014).

The Psychiatric Liaison Team involved in this study is located in an inner city Teaching General Hospital with the A&E Department being one of the busiest in the country. They are a team of mental health nurses, consultant psychiatrists and psychiatry trainees based at the Hospital's A&E Department and provide 24-hour care for the patients in A&E. They are employed by a Mental Health Trust and partly commissioned by the General Hospital. The Psychiatric Liaison Team is managed by senior nurses. Clinicians' working in this team assess people to determine if they need mental health care, and refer them to outpatient or inpatient mental health services for treatment or other services. The Hospital and the Mental Health Trust are part of an academic partnership consisting of a university and three NHS Foundation Trusts (two general hospitals and the mental health trust). The Team assesses adults presenting in A&E who either reside in the catchment area of the hospital or out of that borough. As a result, the social-economic status of the patients differs. The area in which the Hospital is located is one of the most densely populated boroughs in the country with some wards being within the most deprived ten per cent in England, has a diverse (multi-ethnic) population, and employment rate is below that of England. The context for the research is discussed on chapter 3.1.

## **1.6. Summary**

In conclusion, there has been a wealth of studies investigating the causal pathways to self-harm and suicidality, and the epidemiological data on self-harm presentations in A&E (Bergen et al., 2010a). Several studies have examined the prevalence of psychosocial assessments offered to patients who presented in A&E with self-harm or suicide attempts (Mullins et al., 2010) and the findings are variable. The importance of psychosocial assessment is recognised not only with regards to assessing needs, risks and devising aftercare plan, but also in relation to its



therapeutic value (NICE, 2011). Clinicians undertaking psychosocial assessments are often confronted with a heterogeneous population facing a number of adversities, which adds to the complexity of their task. To make sense of this field, it appears important to explore some theoretical perspectives, namely the concept of mental pain, the meaning and motivation for self-harm and suicidal ideation from a psychodynamic perspective and the importance of organisational theories to which I shall now turn.

## **Chapter 2- Theoretical Concepts on Self-harm, Suicidality & Organisational Life, & Service-User Research**

### **2. Introduction**

This chapter will introduce ways of conceptualising self-harm and suicidality using psychodynamic concepts. Psychodynamic theories have been chosen in an attempt to make some sense of self-harm but also in thinking about the therapeutic function of psychosocial assessments. Psychosocial assessments occur in busy and complex healthcare systems that involve mental health clinicians of various disciplines. Thus, this review will consider how some psychodynamic ideas about groups and organisations' processes relate to the task of psychosocial assessments in A&E departments and their therapeutic value. A brief synopsis of the challenges and the opportunities of working in multi-disciplinary teams will be presented. Patient involvement in research will be discussed. This chapter will conclude by setting out the aims of the research. The aim here is not to attempt to present a final and definitive way of conceptualising self-harm and suicidality, but to discuss some key issues that contribute to an understanding of self-harm, suicidality, and working with this population in complex health care systems.

### **2.1. Theoretical Concepts on Self-harm & Suicidality**

#### **i) Mental Pain**

The concept of mental pain has been addressed by a number of authors. Freud (1926) attributed mental pain to feelings of mourning and longing for a beloved person following a traumatic loss. Shneidman (1985; 1993) used the term 'psychache' proposing that negative emotions such as guilt, humiliation, disgrace, grief, hopelessness, and rage turned into a generalised experience of unbearable mental pain. Bolger (1999) defined mental pain as 'brokenness of self' consisting of a sense of woundedness, disconnection from a loved one, loss of self, loss of control

and a sense of alarm. Maltzberger (2004) uses the term mental pain or anguish to refer to experiences of self-disintegration which he views as related to suicidal acts. He argues that disintegration begins with a traumatic life event (for instance, a loss).

Orbach *et al.* (2003a) defined mental pain as a wide range of subjective experiences characterised as an awareness of negative changes in the self and in its functions accompanied by distressing feelings. They consider that there are two main sources of mental pain, namely life stressors with loss being the more common and intense stressor and internally produced pain stemming from earlier traumatic experiences and conflict. Unbearable pain can be thought to have the potential to trigger a wish for self-destruction. When pain reaches a high intensity and when there is no foreseeable change in the future, the person may seek to escape by committing suicide (Orbach *et al.*, 2003a). They have created a scale called the Orbach and Mikulincer Mental Pain Scale (OMMP), which assessed the dimensions and intensity of mental pain. For their research, inpatients and individuals without mental health difficulties were interviewed regarding the definition and experiences of mental pain. Their narratives were analysed using grounded theory and content analysis. Short statements were subsequently produced and structured as a scale with 220 items relating to the experiences of mental pain. The scale was piloted and reconstructed at several stages until its final version was obtained. The analysis yielded a mental pain scale, consisting of forty-five items grouped into nine factors as follows: (1) Irreversibility, (2) loss of control, (3) narcissistic wound, (4) flooded, (5) freezing, (6) self-estrangement, (7) confusion, (8) social distancing, and (9) emptiness. The OMMP is self-rated on a 5-point Likert scale with 44 items. Higher values on each item reflect stronger mental pain.

Suicidal patients were found to be suffering from more intense mental pain compared to non-suicidal patients and healthy controls (Orbach *et al.*, 2003a). With regards to the internal consistency of the scale, Chronbach alpha coefficients for all nine factors were found to be acceptable in a study with a non-clinical sample of 402 Israeli Jewish adults. The OMMP has credible reliability; the test-retest coefficients for the nine factors ranged between 0.79 and 0.94 in the same study. The relationship between mental pain and suicidality was tested in a subsequent study (Orbach *et al.*, 2003b). The study indicated a positive relationship between mental

pain and suicidality. In seven of the nine factors, OMMP differentiated between suicidal inpatients and both non-suicidal inpatients and healthy controls.

Prior to that, Lester (2000) in a study with students found that the intensity of mental pain was associated with current depression and history of suicidal ideation. Olié *et al.* (2010) concluded that higher psychological pain during a major depressive episode distinguished patients with a current or historic suicide attempt from patients without any suicidal history. They devised their own measure for intensity of mental pain with no psychometric properties. Van Heeringen *et al.* (2010) using the OMMP found that levels of mental pain were significantly and positively associated with suicidal ideation and hopelessness. Furthermore, using single photon emission computed tomography (SPECT), they found that high levels of mental pain were associated with areas in brain that are involved in the regulation of emotions (perfusion).

However, Pompili *et al.* (2008) found no difference in mental pain scores between people who had attempted suicide and non-attempters. Levi *et al.* (2008) did not find an association between level of psychological pain and lethality of an attempt. The OMMP was used as a measurement of mental pain for the previously mentioned study.

## **ii) Psychodynamic Thinking about Self-harm & Suicidality**

The OMMP (Orbach *et al.*, 2003a) was developed from psychodynamic concepts. In an attempt to make sense of self-harm, Nathan (2004) uses Klein's (1933) finding that young children constantly struggle between the urge to destroy their objects and their desire to preserve them. Nathan (2004) drew a distinction between self-harm and suicide, by describing suicidal acts as a conscious attack on the body, and self-harm as a conscious intention to preserve the good and get rid of the 'bad' and overwhelming feelings that have contaminated the body. Motz (2009a) also uses the concept of divided self to suggest that in self-harm the division, bad and good, is expressed when the toxic mental states are violently discharged onto the body. In this way one part of the body becomes calm, while the other part of the body is attacked. Motz (2009a) moves on to suggest that the body that has been injured- the victim of the attack, is then tended to and cared for. Therefore, the final aim of the

patient who self-harms is to develop an integrated sense of self and to realise that he/she can contain both good and bad impulses (Motz, 2009a). Similarly, Lindgren *et al.* (2004) suggest that following self-harm, individuals may engage in self-care, which may provide a form of self-comfort, confirmation and validation of self.

Incidents of self-harm are often associated with intense feelings of anxiety, distress, anger, sadness which are experienced as unbearable and therefore, they need to be released. It is thought that people subject their body to an assault by self-harm in order to alleviate those unbearable states of mind; in other words they convert mental pain to physical pain (Motz, 2009a; Straker, 2006). Adshead (2010) suggests that self-harm is a symptom of internal distress, which has both a private and a public message, in that it is hoped that it will be understood and responded to by others. Scanlon and Adlam (2009) understand self-harm as an expulsion of a violent state of mind. Scanlon and Adlam (2009) argue that people who self-harm treat their body with cruelty viewing the body as a poison container, replicating a relationship they had with a violent or abusive parent, who met their own needs through a similar type of cruelty towards them in childhood. This would seem to be consistent with the research evidence that suggests that abuse in childhood is a great risk for self-harm (Lang *et al.*, 2011)

Straker (2006) suggests that many individuals discuss the significance of blood in self-harm and moves on to propose that the sight of blood may 'concretise' emotions, enabling the individual to experience them as real. In addition, the physical pain associated with self-harm may be seen as a source of self-realisation, in that the feeling of pain implies reality and affirms existence (Scarry, 1985). An association between self-harm and dissociation has been demonstrated and it is thought that individuals may self-harm in an attempt to regain a sense of self (Low *et al.*, 2000). Experiences of feeling 'cut-off' and disembodied may arise from an internal experience of psychological emptiness which feels unbearable and may originate from internalising feelings of invalidation, abandonment or isolation (Magagna, 2008). As a result, one may attempt to cope with an intolerable state of emptiness by self-harming.

Bick's (1968) concept of a 'psychic skin' as a container to hold the parts of self together has also been helpful in attempting to make sense of self-harm. Bick (1968)

suggests that maternal containment supports the development of the infant's psychic skin and when containment fails, the infant may resort to 'second skin' defences which are forms of protection using muscular tension to hold the self together and prevent disintegration. It is therefore thought while the skin may act as kind of a psychic container, for people who do not have an internal sense of integration, the internal dis-integration is played out on the body and its surfaces (Motz, 2010).

Nathan (2006) suggests that individuals who self-harm have an absence of a 'good internal object' that can help contain their experiences which in turn results in lack of a secure basis that acts as a model for a self that is able, as a whole being and through supportive relationships to regulate affect (Fonagy and Target, 1997). Nathan (2006) adds that the absence of good internal objects leaves individuals unequipped and therefore, instead of finding a human relationship to contain overwhelming anxieties, the individual may turn to self-harm.

From a developmental point of view, Schachter (1999) conceptualises suicidality in young people as a developmental crisis which may arise in individuals in whom the earlier process of negotiating separateness from the primary object has failed. She argues that considering that the body defines us as separate individuals, the suicidal act can be understood as a wish to relieve the mind and the self from an unbearable experience of separateness.

Lastly, some contemporary writers assert that suicide cannot occur without a split between the mind and the body and detachment from the body through dissociation or physical numbness can facilitate the physically self-destructive act of self-harm (Campbell, 2008). Orbach (2008) considers that both intolerable mental pain and detachment from the body is needed in order for a suicidal act to take place.

Self-harm and suicidality are not homogenous phenomena but multifaceted and heterogeneous, and therefore, they can be understood by many theories. However, the aforementioned concepts can help clinicians to make some sense of the inner world of the self-harm and suicidal patient, and are consistent with the research body that has identified difficulties in the early life and care of people at risk of self-harm (Fliege et al., 2009; Lang et al., 2011). Furthermore, they can be helpful in addressing the relational and therapeutic aspect of the psychosocial assessment.

## **2.2. Organisational Life**

### **i) Anxiety in Organisations**

Bion (1961) studied group processes in organisations and described the work group and the basic assumption group culture. The work group mentality refers to groups that perform tasks associated with the official purpose of the group and are able to learn from experience in order to achieve its tasks (Bion, 1961). The basic assumption culture characterises groups that unconsciously tend to avoid work on the official task. These opposing tendencies can be thought of as the wish to face and work with reality, and the wish to avoid it when it is painful or causes conflict between or within group members (Stokes, 1994). Bion (1961) distinguished three basic assumptions each having an emotional culture: dependency, fight/ flying and pairing. The group during dependency functions as if its primary task is to fulfil the needs of its members and the leader is idealised. In the fight/flight mentality, the group perceives a danger or enemy that needs to either be attacked or fled from and as a result the group avoiding its tasks either by fighting or fleeing. Lastly, pairing refers to the group's firm belief that pairing or coupling between members within the group, will save and strengthen the group. In the life of a group, its members are thought to oscillate between the mentality of a working group and the basic assumptions. However, while the work group culture and its focus on the primary task relates to the survival of the group in accordance with the demands of the external world/reality, the basic assumption mentality is driven by the demands of the internal environment and anxieties about survival (Roberts, 1994).

Menzies-Lyth (1970), through her observations of nursing in a general hospital, noted the anxiety aroused by the work itself, in particular the close involvement with illness and death, and the intimate physical contact with patients. She highlighted that anxieties were present in everyone to some extent and could be stirred up in specific ways for nurses by the task of looking after ill patients in the hospital. She identified behaviours which she called socially organized defences; those were manifested by nurses as a way of coping with the anxiety and conflict engendered by the nursing tasks. In summary, these defences included: detachment and denial of feelings or interest in individual patients, referring to them as 'the liver in bed 10' instead of using their names; viewing patients and themselves as

interchangeable and the idea of rapid redeployment from one ward to the next supposedly in the interest of nurses gaining a broad experience which diminished any opportunities for continuity of care, a reductionist narrowing of the focus of the work (for example, one nurse taking all the blood pressure readings) rather than holistic care with one patient; avoiding any expression of individual initiative or decision-making by mandating that all nursing tasks were prescribed from superiors which resulted in junior nurses viewing themselves as 'irresponsible' regardless of their skills and abilities (Menzies-Lyth, 1970).

All of these defences were thought to aim at reducing the anxiety aroused by the intimate physical and emotional involvement with ill patients. However, Menzies-Lyth (1970) did not describe these social defences as the result of individual nurses' personalities but as embedded in the culture and training of the nursing staff. She suggested that these defences were ineffective as the nurses were still experiencing the difficult emotional demands of the work, but had become disengaged from the patients. This resulted in them not being able to think and acknowledge emotional aspects of their work, and work through feelings of loss, helplessness or guilt.

Whilst the experiences of clinicians working in Psychiatric Liaison have not been adequately studied, research in inpatient units for people who self-harm has revealed that mental health clinicians felt burdened and overwhelmed by feelings of anxiety, fear, and frustration (Wilstrand et al., 2007). Professionals working with self-harm can feel hopeless, anxious, incompetent or angry mirroring the experiences of their patients. The additional complexity is that professionals may respond in a shocked and angry way to self-harm patients due to their own anxieties about self-harm being fatal or causing irreparable damage (Motz, 2009b). In the face of intense and unbearable feelings experienced in the countertransference throughout their working day as the primary task of Liaison Teams is to assess people presenting in A&E with self-harm and suicidality, clinicians may at some points avoid making any emotional connection with the patients and defensively focus on rational thinking and symptoms at the expense of the patient's emotional turmoil.

This would be detrimental to the process and the outcome of psychosocial assessments as experiences of being perceived, understood and accepted by clinicians serves to alleviate the distress and aloneness in patients and as a result



helps the patient to begin to bear what have previously been intolerable states (Schechter and Goldblatt, 2011) and possibly led to the self-harm episode. Mentalising is the process by which people make sense of each other and themselves, implicitly and explicitly, in terms of subjective states and mental processes (Bateman and Fonagy, 2010). Experiences of being understood and accepted can help the patients to start mentalising in the midst of unbearable mental state rather than being emotionally overwhelmed in non-mentalising suicidal states (Wenzel and Beck, 2008). In keeping with this, qualitative research on service-users' experiences of psychosocial assessments found that psychosocial assessments were valued when patients felt that their needs were legitimised (Hunter et al., 2013).

In conclusion, working with patients who self-harm and present in A&E for psychosocial assessments is complex and definitely emotionally demanding for the clinicians undertaken the psychosocial assessments. Social defence systems in health care services may be unable to contain anxieties in its members which in turn can result in difficulties in the performance of the task (Menzies-Lyth, 1970). These may, to some extent, relate to the experiences patients report with regards to psychosocial assessments in A&E. Therefore, psychodynamic ideas about groups and organisations can help to make sense of the difficulties encountered by clinicians and patients, and as a result, consider ways of improving the therapeutic quality of the psychosocial assessment and organisation life on the whole.

## **ii) Working in Multi-disciplinary Teams**

A number of models have been found in the literature to describe the collaboration between disciplines in multi-disciplinary teams (Collin, 2009). Three models appear with greater frequency than any other; these are: multi-disciplinary, interdisciplinary, and trans-disciplinary (Deady, 2012). More recently the concept of multi-professional teams has been used (West et al., 2012); nevertheless, all terms appear to convey the notion of bridge building between various disciplines toward a particular goal or goals that require some degree of restructuring of thought and practice (Burke and O'Neill, 2010). Multi-disciplinary working is an established model of working within current mental healthcare in recognition that the issues arising in mental health care are of greater complexity

and breadth than can be comprehended and responded to by one discipline alone (Vetere, 2007). It is considered that in multi-disciplinary teams, professionals with different disciplinary backgrounds can address a range of complex problems in the management and care of service-users with mental illness through an open exchange of their skills and ideas (Colombo, 1997). A recent literature review (Evans et al., 2012) of multi-disciplinary teams specifically in the area of community mental health teams found that the composition of teams was not often well justified in terms of effectiveness, despite some evidence that greater professional diversity was associated with higher effectiveness.

Granville and Langton (2002), among other writers, discuss the tension between specialism and generalism, and they highlight that a key issue for clinicians working in multi-disciplinary teams is negotiating the boundary and relationships between the different disciplines maintaining and valuing the distinct skills and knowledge each discipline offers. Lawrence (2000) developed the idea of primary task as a way of examining organisational behaviour by suggesting that people within an organisation pursue different types of primary task, namely the normative, existential and phenomenal primary task. He defined the normative primary task as the formal or official task. The existential primary task refers to the task professionals within the organisation believe they are carrying out and the meaning they assign to roles and activities. Finally, the phenomenal primary task is the task that can be inferred from professionals' behaviour, and of which professionals may not be aware. Roberts (1994) proposes that analysis of the primary task as described by Lawrence can highlight discrepancies between what an organisation says it sets out to do and what is actually happening. Lankshear (2003) studied the strategies that six multi-disciplinary teams employed to manage the problems created by the disparity between the stated and agreed purpose of the teams. A number of strategies were identified to manage this fundamental conflict namely, isolation, homogenisation, fraternisation, negotiation and manipulation. Lastly, demarcation was used in order to ameliorate the loss of professional identity experienced by some members (Lankshear, 2003).

It has been advocated that multi-disciplinary teams, more than uni-disciplinary teams, struggle to create a coherent and shared purpose, considering

that their members have different trainings, values, priorities and preoccupations (Stokes, 1994). In addition, individual members may lack clarity about their own distinct professional roles. Interestingly, a recent qualitative study using grounded theory revealed a lack of agreement among participants with regards to the structure, formulation, and practice of their multi-disciplinary team (Deady, 2012).

Stokes (1994) advocates that where a group has no clearly defined and agreed primary task, the tendency to basic assumption mentality is far greater since there are no obvious criteria for members to tell whether a particular topic or activity is relevant to the task or not. In addition to differences that occur between people in multi-disciplinary teams due to professional identity and educational background, multidisciplinary teams have to cope with differences in pay, status, and attitudes (Lankshear, 2003). Stokes uses Bion's (1961) concept of the sophisticated use of basic assumption in the context of the multi-disciplinary teams. Bion (1961) suggests that a group may utilise the basic assumption mentalities in a sophisticated way, by mobilising the emotions of one basic assumption in the constructive pursuit of the primary task. Stokes (1994) argues that one of the difficulties in making a team out of different professions is that each profession operates through the deliberate harnessing of different sophisticated forms of basic assumption in order to further the task. He adds that conflict may emerge since the emotional motivations of each profession differ; nevertheless, collaboration on a task is possible provided that there is a process of clarifying shared goals and ways of achieving these.

Within the field of mental health and probably health generally, doctors and nurses have shared a rather complex relationship characterised by different social status, gender, power, and perspectives (Salvage et al., 2000). Fagin and Garelick (2004) consider that the nature of the psychiatrist–nurse interaction is changing in substantial ways and that nurses and doctors are now becoming equal partners in the clinical domain. They go on to further advocate that it is the mutual interdependence of nurses and doctors that will facilitate true collaborative clinical work in psychiatry. From a different point of view, a review conducted by Brimblecombe *et al.* (2005) concluded that psychiatrists in the UK remain highly

influential, despite the move from their traditional power base in hospitals. Nevertheless, changes in mental health care, such as new nurse prescribing powers were thought to result in a change in the relationship between mental health nursing and psychiatry (Brimblecombe et al., 2005). In mental health, nurse prescribing remains limited but is growing (Kwentoh and Reilly, 2009). A recent survey found that the UK standards of non-medical prescribing have been met; however, a shortfall was identified in the uptake of supervision and training (Gumber et al., 2012). Psychiatrists' attitudes towards mental health nurses prescribing varies (Earle et al., 2011; Rana et al., 2009).

In conclusion, multi-disciplinary teams are well established across mental health services in an attempt to address the complex and multiple needs of patients. Clinicians in multidisciplinary teams are confronted with differences in perspectives, professional identity, pay, education, status, and attitudes (Lankshear, 2003). Øvretveit (1995) argued that a multi-disciplinary team without differences is a contradiction in terms. The challenge is for the team to use these differences between concepts, values and training as an opportunity to develop ways of joint working and appropriate care. Clarity and on-going discussion about the primary task of the organisation, clear authority structures and support (Obholzer, 1994) are thought to facilitate the development of a multi-disciplinary team. Evans *et al.* (2012) underline the need for adequately skilled multi-disciplinary teams.

### **2.3. Service-User Involvement in Research**

All National Institute for Health Research programmes encourage researchers to involve service-users in research (Staley et al., 2013). Service-users' priorities for mental health research have previously been studied and compared with established priorities (Rose et al., 2008). The study found that the service-users had different priorities (user involvement in research, social issues and medication being the most prevalent being their main priorities) compared to the professionals and only three priorities overlapped namely, in-patient wards, access to psychological therapies and dual diagnosis (Rose et al., 2008).

The emerging agenda of service-user research is considered to have many parallels with the interest of mental health researchers in psychosocial aspects of mental illness (Fleischmann, 2010) and giving patients a much greater say in their treatment in the 'post-modern psychiatry' (Tyrer, 2002). Hickey and Kipping (1998) described service-user involvement as the democratisation of research considering that power is redistributed to those who access mental health services. Four levels of service-user involvement in research have primarily been described, namely consultation, collaboration, user-controlled research and contribution (Sweeney and Morgan, 2009). Faulkner (2012) suggests that it may be helpful to imagine a continuum with service-user survivor (or service-user controlled research) at one end and consultation at the other end, with the middle being occupied by many variations on the theme of service-user involvement and collaborative research.

The benefits of service-user involvement in research are thought to be the following: increase relevance of research, better recruitment to studies and better more open responses from research participants who are more likely to feel their interests are being addressed, less likelihood of dropouts, fresh insight in interpreting the results, service users may support with dissemination and implementation of research findings and finally, more ethically sound research (Szmukler, 2009). However, the actual evidence concerning the benefits of service-user involvement in research are emerging (Faulkner, 2012; Szmukler, 2009; Tyrer, 2002),

Vale *et al.* (2012) surveyed service-user involvement and found that researchers generally stated that the service-users involvement was beneficial and reported a range of positive impacts namely, improved design, quality, recruitment and dissemination. Similarly, Staley (2012) randomly selected forty-five studies registered in the Mental Health Research Network at different stages of completion exploring the impact of the service-user involvement. The study found that in some projects the service-users had a major impact on the study design and recruitment, however, in other projects their impact was minimal. Twenty percent of the researchers involved service-users as co-researchers or as a member of the advisory group. These types of involvement impacted on every aspect of the research and led to improvements in recruitment, retention and quality of interviews as well ensuring that the research addressed issues important to service users.

Finally, just under twenty percent of the studies consulted service-users at the design stage and their impact was found to vary considerably. A systematic review concluded that service-user research enhanced the quality and appropriateness of research but the evidence base was considered to be weak (Brett et al., 2014).

There is some evidence to suggest that when participants are interviewed by service-user researchers, they report more negative comments about their experiences of services compared to when they are interviewed by clinical researchers (Gillard et al., 2010). A study found that when structured scales are devised by service-user researchers, participants report less satisfaction with treatments than when they respond to a scale designed by clinical researchers (Rose et al., 2003). Rose *et al.* (2011) did not find any differences between participant information elicited by service-user researchers and clinical researchers.

With regards specifically to self-harm, a recent review demonstrated that service-user involvement is rare in the evaluation of psychosocial interventions for people who self-harm (Ward et al., 2013). The authors also referred to the small sample sizes recruited in research in the field of self-harm and hypothesised that this may relate to the stigma service-users often feel following self-harm (Ward et al., 2013). Hunter *et al.* (2013) explored patients' experiences of psychosocial assessments in A&E following an episode and reported to have involved service-users in the research design phase. Furthermore, Hunter as the lead researcher, stated that her approach as a researcher was influenced by her experience of people who self-harm on personal and professional basis. However, the impact of the service-user involvement was not clear.

Beresford and Evans (1999) argues that service-user involvement in research values people's first hand direct experience as a basis for knowledge. However, the idea of involving service-users in research has received some criticism. Involving service-users in research may be seen as introducing bias to research studies considering that service-users are not neutral to the research theme. In response to this, Rose (2008) suggests that all research comes from a particular standpoint that infuses its epistemology, its methodology and the knowledge produced as a result. In other words, Rose (2008) asserts that clinical researchers bring to their research a clinician's view of what may be beneficial for a particular condition and therefore,

similarly to service-user researchers, they are neither neutral nor unbiased. Rose (2011) highlights the need to continuously reflect on the research process in order to ensure that the researchers' preoccupations are not imposed on the participants. Both of the aforementioned points seem to be pertinent to all types of research and not solely relevant to the studies engaging service-user researchers.

A further point about service-user involvement in research is made by Frankham (2009) who in a non-critical way and refers to the issue of representativeness. More specifically, Frankham (2009, p. 16) writes:

*'In suggesting that one person 'knows' what it means to live with a learning disability, for example, that individual is taken to be representative of a group who share that characteristic. These accounts, then, can act as a new form of ventriloquism- one person speaking for others- and to the homogenisation of groups of people, as accepted accounts of what this experience means are repeated and reified'.*

There has been very little work to attempt to explore the differences between those service-users who are actively involved in research projects and those who are not. A pilot study with a very small sample found no difference between patients participating in service-user groups and those who did not with regards to diagnosis and length of use of mental health services (Rose et al., 2010).

Moving on to challenges, it is thought that service-users may be more likely to need time off work or may not be well enough to work full time job (Staley et al., 2013). Faulkner (2012) suggests that researchers fear that involving service-users in research will have a negative impact on the quality of research because they have limited research skills. As a result, she argues that involving service-users in research requires additional resources in terms of money and time such as research training. There are currently a number of publications that offer guidance on training and support for service-user researchers (Sweeney et al., 2008). One perhaps needs to bear in mind that any researcher with limited experience is also likely to require training and additional support. Staley et al. (2013) have found that some researchers have very narrow expectations of service-user involvement in research and as a result, its impact. Hence, while training service-users in research is considered to be important, training clinical researchers in how to collaborate with service-users appears equally significant.

In conclusion, collaborative research between service-users and clinical researchers in mental health is a developing field. The concept of service-user involvement in research is variable from consultation to service-user led research (Faulkner, 2012). Service-user researchers are considered to come to the research endeavour with a different perspective to professionals, and are thought to be able to elucidate how services and treatment feel to service-users from the inside (Rose, 2003).

There is emerging evidence to suggest that involving service-users in research improves its quality and relevance (Staley et al., 2013). Further research is needed for example with regards to whether service-user researchers obtain information that differs from that obtained by clinical researchers (Rose et al., 2011). Despite recommendations for service-user involvement in research, researchers are facing challenges in taking forward involvement as the research infrastructure is not always facilitative (Staley, 2012; Staley et al., 2013). An interesting aspect of service-user research is how the emphasis on the value of the service-user researcher's individual can be reconciled with the need to create generalisable knowledge that can be used to improve services (Fleischmann, 2010). As far as self-harm is concerned, the NICE guidelines (2004) strongly recommend user-led qualitative research. Service-user involvement in the evaluation of psychosocial assessments and interventions is very infrequent and this is thought to be a significant gap in the current literature. Considering the importance of psychosocial assessments following episodes of self-harm and/or suicidal ideation and the current gaps in the literature, the involvement of service user researcher would seem significant in exploring patients' experiences of psychosocial assessment and what they find helpful and not helpful.

## **2.4. Summary & the Need for Further Research**

This chapter has considered the concepts of mental pain, other psychodynamic concepts, organisational parameters related to mental health practice and the role of service-users in conducting research. Self-harm and suicidal ideation are associated



with a high risk of suicide and other adverse outcomes (Bergen et al., 2012a) and psychosocial assessment is a crucial component of management (Kapur et al., 2013). Psychosocial assessments are complex pieces of relational/ interactional work with therapeutic quality that need to address the heterogeneity of self-harm presentations and its multiple risk factors. Thus, it seems important to make use of theoretical perspectives to make sense of these processes considering the discussion in chapter 1 about the role and importance of psychosocial assessments.

As a result, of the discussions in both this and the previous chapter, this study aims at an in-depth exploration of how clinicians working in the field of psychiatric liaison, in multi-disciplinary teams and in complex organisations, undertake psychosocial assessments, in response to self-harm and suicidal ideation. More specifically, through a combination of qualitative methods this study will explore:

- what are the experiences people with self-harm<sup>1</sup> or suicidal ideation<sup>2</sup> narrate during psychosocial assessments in A&E? What differences and similarities exist between self-harm and suicidal ideation psychosocial assessments in A&E carried out by a Psychiatric Liaison Team?
- what are the attitudes, feelings, and experiences of clinicians carrying out psychosocial assessments for patients who self-harm or present with suicidal ideation in A&E?
- what is the process of the Psychiatric Liaison Team making decisions about treatment/interventions offered following psychosocial assessments?

The next chapter will discuss how the study's methodology was developed.

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<sup>1</sup> As defined by NICE (2011) and the concept of self-harm includes suicide attempts.

<sup>2</sup> As defined by the Centre for Disease Control and Prevention (2013) and will be used instead of the term suicidal crisis.

## **Chapter 3- Methodology**

### **3. Introduction**

This chapter will focus on methodological issues related to the study. It will start by describing the wider study from which the current study developed. Following that, the aims of the study will be stated. It will briefly note ontological and epistemological issues influencing the study and there will be a discussion about mixed methods research. As this study is influenced by various epistemological perspectives, and multiple methods are employed, the concept of 'bricolage' in research will be mentioned. The chapter will then describe sampling, data collection and analysis. A discussion about the quality of this study will take place regarding credibility, triangulation and generalizability. The researcher's position in relation to this study will be thought of. Finally, ethical issues will be considered.

### **3.1. Background to the Study**

This study follows a larger project in the A&E Department of a Teaching Hospital which investigated the relationship between background social factors, psychiatric diagnoses, and suicidal/self-harm histories, the treatments offered and the treatment outcomes (Briggs and Glen-Day, 2008). The project aimed, through retrospective study of patients referred to the hospital after a suicidal or self-harming episode, to assess the characteristics of these patients and to explore whether and how these could be shown to relate to the interventions provided after these episodes and the outcomes for these interventions. More specifically, the aims were to assess:

- demographic, psychiatric and social factors
- the intervention or treatment allocated
- exploration of outcomes of treatment, including reduced risks, problems and symptoms and re-referral and repeat episodes of self-harm/ suicide attempts

- patterns of use of multiple interventions over time which lead to the elucidation of pathways of care.

The methodology used was a comprehensive retrospective study of routinely collected data. The data-set encompassed 596 psychosocial assessments of 484 patients presenting following an episode of self-harm, a suicide attempt or a suicidal crisis over a period of eight months. The psychosocial assessments were undertaken by the Psychiatric Liaison Team of the A&E department following initial assessment and occasionally treatment by A&E nurses and doctors.

### **3.2. Aims & Research Design**

Through the preliminary results of the quantitative analysis of the 596 psychosocial assessments, and reviewing part of that data, new research questions emerged in relation to the process of assessment and care planning which could be addressed with qualitative methods. Through a combination of qualitative methods this study aimed at exploring:

- what are the experiences people with self-harm (SH) or suicidal ideation (SI) narrate during psychosocial assessments conducted by a Psychiatric Liaison Team in A&E with regards to biopsychosocial parameters and the categories of the OMMP (Orbach et al., 2003a)? What differences and similarities exist between SH and SI psychosocial assessments in A&E carried out by a Psychiatric Liaison Team?
- what are the attitudes, feelings, and experiences of clinicians carrying out psychosocial assessments for patients who SH or present with SI in A&E?
- what is the process of the Psychiatric Liaison Team making decisions about treatment/interventions offered following psychosocial assessments?

The quantitative study answered questions such as 'how many' or 'how frequently'. The current study aims at exploring in detail what is discussed between clinicians and patients, how clinicians make sense of and respond to patients, and how aftercare plans are formulated. Thus, a qualitative research design is chosen

considering that qualitative methods imply an emphasis on the qualities of entities, on processes and meanings that cannot be experimentally measured (Denzin and Lincoln, 2013).

### **3.3. Ontology, Epistemology & Methodological Considerations**

Ontology is a philosophical belief system about the nature of social reality- what can be known (Corbin and Strauss, 2008). A key issue in qualitative research is whether social entities are objective entities that have a reality external to social actors or whether they are social constructions made up from the perceptions and actions of social actors; these different positions are referred to respectively in the literature as objectivism and constructionism (Bryman, 2001). Epistemology refers to how we know and the relationship between the knower and the known (Maxwell, 2011). A broader use of the concept of epistemology also includes ontology and sometimes methodology (Maxwell, 2011). Denzin and Lincoln (2013) use the term 'paradigm' to refer to the net that contains the researcher's epistemological, ontological and methodological premises.

#### **i) Qualitative Research Methods**

Lincoln and Guba (2000) argued that the appropriate epistemological paradigm for qualitative research was constructivism, the position that our understanding of reality is a social construction, not an objective truth, and that multiple realities exist. Denzin and Lincoln (2000) argue that qualitative research can be divided into postpositivism, constructivism, realism and postmodernism.

This study has partially been influenced by constructivist-interpretivist ideas. Denzin and Lincoln (2013) suggest that this position assumes that social phenomena are actively produced and revised, and that knowledge is both subjective and partial as well as that there is no one definitive social reality. This study, therefore, does not search for the 'truth' about SH and the clinician-patient relationship but acknowledges that they can be understood from different, equally valid, perspectives.

The way of viewing SH, SI, mental illness and treatment has been influenced by the notion that some illnesses are particularly embedded with cultural meaning that shapes how people respond to those affected and influences the experience of that illness (Conrad and Barker, 2010). It is recognised that illnesses can be socially constructed at the experiential level, based on how people make sense and live with their illness (Charmaz, 1991). It is of course acknowledged that illnesses have biomedical dimensions. The genetic and biological parameters related to mental illness (and physical illness) are by no means disregarded. Hence, this study is also influenced by realism (Denzin and Lincoln, 2005).

The study has been influenced by Hacking (1999) who suggests that several objects of constructivist claims, such as mental illness cannot be simply analysed as either 'real' or 'social construction' and how both realist and constructivist approaches can make a contribution to the understanding of a phenomenon. From a similar viewpoint, Maxwell (2011) asserts that qualitative research can be conducted from different and opposing ontological and epistemological perspectives. Although it is appreciated that social constructivist and realism seem to be at odds with each other, it is thought that the use of multiple paradigms in a one study contributes to greater understanding of the phenomenon that is being researched (Greene and Caracelli, 2003). This seems particularly important considering that SH and SI are complex and heterogeneous phenomena in that not all people who SH or experience suicidality face the same problems. Furthermore, people who SH and/or experience SI may encounter multiple psychosocial, social and environmental stressors. Also, SH and SI may have different meanings according to each individual's circumstances and predicaments.

In addition, this study has been influenced by the work of Scourfield *et al.* (2012) who highlight the complexity of individual cases and a psychosocial approach in studying suicide due to the complexity of this phenomenon. They add that emotional states are viewed not just as individual experiences but as inter-relational complexes in which wider psychosocial factors are implicated. This way of thinking seems very relevant to SH and SI, and how they are treated.

## **ii) Mixed Methods Research**

Several definitions for mixed methods research have emerged over the years (Creswell and Plano Clark, 2011). There has been some agreement that mixed methods research means adopting a research strategy which employs more than one type of research method (Teddle and Tashakkori, 2010). Mixed methods research often refers to employing quantitative and qualitative research methods. The use of multiple qualitative methods can also be referred to as mixed methods research (Fielding and Fielding, 2008). Mixed methods research also denotes working with different types of data (Bergman, 2008). Teddlie and Tashakkori (2010) suggest that mixed methods research emerged partially out of triangulation literature, which has commonly been associated with the convergence of results. They though recognise that divergent results in mixed methods studies can provide greater insight into complex aspects of a phenomenon. Brannen (2005) warns that data collected from different methods cannot simply be added together to produce a unitary or rounded reality or truth.

As previously noted, this study emerged from a quantitative study and will employ various qualitative methodologies. It is, therefore, considered to be a mixed methods study. The current study uses a subsample of psychosocial assessments derived from the whole sample (596 psychosocial assessments) and recruits participants conducting psychosocial assessments in A&E. The rationale for choosing a mixed methods study is to attempt to understand a complex problem being treated within complicated health care systems from different accounts in a complementary way using quantitative and qualitative findings. It is, thus, hoped that a mixed methods study would bring a more comprehensive way of understanding psychosocial assessments for SH and SI.

The qualitative study benefits from drawing its sample from the large data-set used for the quantitative study as it is possible to select particular psychosocial assessments, and to draw upon contextual information from the large quantitative study. Similarly, the two qualitative methods (related to two data sets) that are used are hoped to enhance each other's findings. Finally, the mixed methods methodology intends to bring together, statistical data, and the voices of clinicians and service-users.

There are major disagreements in the literature regarding designing integrated research; nevertheless, there is agreement about the importance of identifying a sequence of phases and the type of data that is needed for addressing the research questions (Tashakkori, 2009). This is a sequential iterative study both in terms of the data collection and the data analysis. The data for the quantitative study was gathered and analysed prior to the beginning of the qualitative study, and subsequently informed the data collection and analysis of the qualitative study. Research questions and aims for each phase develop as the study evolves (Tashakkori and Creswell, 2007). The strength of this approach is that researchers build into their design the impact of one method on another (O’Cathain, 2010). Whilst there is no overarching mixed methods question, primarily due to the fact that this is not a concurrent study, the aim is that some of the follow-up qualitative findings may enlighten the initial quantitative findings, for example the quantitative study has explored treatment outcomes and the qualitative study can help making sense how clinicians decide what treatments to offer.

Bryman (2006) writes about the ‘paradigm wars’ referring to the debate about quantitative and qualitative research. Some authors point out the different epistemological and ontological assumptions underpinning qualitative and quantitative research and assert that they cannot be combined (Creswell and Tashakkori, 2007). Others allow for the merging of the two approaches within research designs (Bryman, 2006). It is now thought that the ‘paradigm wars’ can be considered over and some firmly assert that the incompatibility thesis with regards to mixed methods research has been discredited (Teddlie and Tashakkori, 2010). A study concluded that researchers are not usually concerned about the possibility that their use of mixed methods research transgressed epistemological and ontological principles (Bryman, 2008).

Tashakkori and Teddlie (1998) refer to the ‘dictatorship of the research question’ in an effort to bring the importance of the research question to the centre of the on-going discourse, and to move researchers beyond the paradigm debate. They note that in some mixed methods studies the questions of a later phase develop as a reaction to the inferences of the previous one which is the case for the current study. Some researchers who combine quantitative and qualitative research are influenced

by the pragmatic paradigm (Tashakkori and Teddlie, 1998) as they are of the view that certain types of research require certain types of methods. This study is influenced by the idea that multiple paradigms related to different research phases can be used in mixed methods research (Creswell, 2011). Whilst the quantitative phase may reflect a postpositivist learning, the qualitative phase that followed was influenced by the paradigms described previously (constructivist and realism).

The concept of 'bricolage' seems relevant to this study. 'Bricolage' research as conceptualised by Denzin and Lincoln (2000) is multi-perspectival, multi-theoretical and multi-methodological approach to research. For Denzin and Lincoln (2000), adopting a 'bricolage' approach helps researchers to appreciate the complexity of meaning-making processes and the contradictions of the lived world. Whilst this study has not fully followed the approach of 'bricolage' and its theoretical/philosophical underpinnings, it views SH and the psychosocial assessments carried out by clinicians in A&E situated in complex health care system as a phenomenon that benefits from various theoretical and methodological approaches in research. Furthermore, as previously described, it considers SH and SI to be multi-faceted phenomena. For these reasons, it has been influenced by the concept of 'bricolage' in research.

The study consists of two stages; the initial stage involves studying psychosocial assessments with the use of a thematic analysis and the second stage involves studying the attitudes and experiences of clinicians using two different qualitative methods as well as consulting service users about the findings. The methods used in each stage will be discussed below.

### **3.4. Stage 1: Exploring Patients' Experiences through Assessment Records**

#### **i) Sampling & Data Collection**

Recruiting patients who SH in qualitative research has proven to be very difficult and most studies include very small samples (Hunter et al., 2013). Studying case notes is anticipated to both offer an insight into how patients' experiences are constructed by clinicians as well as some insight into the psychosocial circumstances of these



individuals. Case notes are considered to be rich, naturally occurring and accessible data (Silverman, 2011). Thus, it was decided to study in-depth records of psychosocial assessments. There was a readily available sampling frame, namely a data set of 484 patients who presented on 596 occasions over the period June 2008-January 2009 to the A&E Department, from which to draw a sample. More precisely, the sampling frame included male and female individuals aged 17 to over 70 years old who were assessed by the Psychiatric Liaison Team following an episode of SH or SI.

For the purposes of this study, a purposive theoretical sample is drawn in an attempt to allow for a broad range of responses and comparisons. The sample size is estimated following in depth examination of the quality and richness of the data. In addition, the sample size aims at reflecting the diversity of the data with regards to the professional discipline and seniority of the clinicians carrying out the psychosocial assessments. Other relevant factors are considered, namely the scope and design of the study, and the heterogeneity of patients who SH (demographics, risk factors, means and lethality). Finally, the examination of the data revealed dimensions and aspects not previously thought of, such as the population who repeatedly presents to A&E either with SH or SI. Therefore, the number of patients and assessments included in the sample is responsive to the data and the analysis rather than established before the current study begun. An iterative process is followed: data collection leads to preliminary analysis which in turn leads to concepts and further questions which consecutively leads to more data collection.

Taking all the aforementioned into consideration, two subsamples of 20 patients are drawn from the data set; one is formed by patients who presented with SI and the other with patients who presented with SH (see Appendix B). As a number of patients represented to A&E for an assessment, the total number of assessments included is 61. Many definitions and perspectives are found in the literature regarding the concept of saturation. Bryman (2012) describes saturation as a process in which the researcher continues to sample relevant cases until no new theoretical insights are being gleaned from the data. As previously noted SH and suicidality are highly heterogeneous phenomena which makes saturation difficult to

be fully reached. Saturation was achieved with regards to the main overarching themes (conceptual categories).

The main advantage of using documents in research is considered to be their ability to offer insight into actions and processes that cannot usually be directly observed (Shaw, 2011). Hak (1992) demonstrates how the clinical notes display the expertise of psychiatrists (and other professionals) and serve to confer identities and qualities to the patient that the hospital or health service will draw upon to justify the management of the patient. This argument is very pertinent to the use of documents in research and constitutes the main limitation of the method chosen here as patients identities and histories have been constructed through the psychosocial assessments- as documents- and influenced by the way clinicians make sense of the patients' difficulties, to some extent, and possibly organisational variables.

## **ii) Analysis**

Thematic analysis is used to analyse the data for this study, which is a method that describes the data set in detail, seeks patterns, and highlights similarities and differences across the data set (Braun and Clarke, 2006). It, then, moves on to offer interpretations in relation to various aspects of the research topic (Boyatzis, 1998). The aim of collecting data from the assessment records is to explore in detail and to identify themes regarding patients' SH/SI experiences that led them to A&E as those emerge in the psychosocial assessments. Therefore, thematic analysis is considered as a suitable method for this exploratory study due to its focus on the rich description of the entire data set -on this occasion the content of the psychosocial assessments and the experiences patients narrated-, and the succeeding move to interpretations. Thematic analysis is a flexible approach that can allow for social as well as psychological interpretations of complex and multi-dimensional phenomena such as, SH and SI (Braun and Clarke, 2006). It is particularly well suited to large data sets (Guest et al., 2012).

Qualitative coding is the process by which segments of data are identified as relating to, or being an example of, a more general idea, instance or category (Lewis and Silver, 2007). Codes are primarily generated in two ways. Firstly, an inductive approach is used in an attempt to avoid existing theoretical concepts to define the

analysis. The identified codes are strongly linked to the data, and there is not an attempt to fit codes into a pre-existing coding framework. It is acknowledged that data are never coded in an epistemological vacuum (Braun and Clarke, 2006). Hence, it is likely that my professional orientation and experiences influence to some degree the inductive approach to coding. Secondly, an existing theoretical framework is applied which constitutes a deductive approach in the coding process. The nine core principles of the OMMP, namely irreversibility, loss of control, narcissist wounds, emotional flooding, freezing, self-estrangement, confusion, social distancing, and emptiness (Orbach et al., 2003a) (see chapter 2) were incorporated into a coding schema which was developed before the coding of the text begun.

One of the most prevalent criticisms about coding is conveyed by Hollway and Jefferson (2000). They suggest that fragmentation of qualitative data results in neglecting the whole- interview or text. They add that the whole is not only greater than the sum of its parts, but by keeping in mind the whole one gains an understanding of the parts, rather than vice versa. The main criticism of thematic analysis is that it abstracts issues from the way they appear in life and organises material according to the researchers' sense of how it connects, rather than the inter-relationship of themes in the participant's mind or life (Boyatzis, 1998). Finally, there is no clear agreement about what thematic analysis is and how it is done (Attride-Stirling, 2001).

The method of thematic analysis described by Braun and Clarke (2006), and Joffe and Yardley (2004) is used with a minor amendment which will be discussed further below. The analysis of the assessments is assisted by NVivo 9 software for qualitative analysis (QSR, 2010).

### ***Inductive Thematic Analysis***

**Initial Coding- Thematic Categories & Sub-Categories:** The 61 psychosocial assessments are carefully read. Initial codes are, then, generated in a systematic way across the entire data set, collating data relevant to each code. The codes transform segments of the raw data into meaningful groups (see Appendices C.1 and C.2 for examples of codes). The entire content of the data is coded. Qualitative software have been criticised for fracturing the data at the expense of other analytical

processes (Lewis and Silver, 2007). Hence, multiple codes are occasionally used to code the same data rather than fracturing text about it across several codes. A list of codes (categories) identified across the data is subsequently produced (see Appendix C.3, for an example of the categories and subcategories 'Clinicians' formulation of SH' and 'Clinicians' formulation of SI').

Whilst constant comparison is primarily used in grounded theory (Corbin and Strauss, 2008), it is considered to be relevant in any analysis in order to identify similarities and differences across the data. Therefore, each code is compared with the rest of the codes and the collated data. During that stage some codes are merged and others are separated. In addition, there are occasions when it is very difficult to make sense of a narrative/incident and as a consequence, impossible to classify it. These instances refer primarily to medical illnesses and terminology. Hence, theoretical comparison is employed (Corbin and Strauss, 2008). Similar incidents in the literature are identified (for instance, experiences of psychotic symptoms by people who have undergone thyroidectomy) and various concepts/meanings are derived from the literature to examine, make sense and comparisons with the data.

**Thematic Groups & Conceptual Categories:** During the second stage codes are analysed in an attempt to consider how different codes can be grouped together to form an overarching theme. Therefore, different codes are grouped into potential broader themes (thematic groups). The themes are, then, connected into a branching system of themes (conceptual categories) (see Appendix C.4, for an example). However, a few codes are placed in two thematic groups and, thus, further refinement is necessary. A few codes do not fit in the hierarchical system of themes. A provisional thematic map (or codebook, coding frame, coding manual) of the analysis is generated at the end of this stage.

**Thematic Map:** Firstly, the themes are firmly defined which allowed for a higher order abstraction and interpretation. The themes are checked in relation to the coded extracts, and all the data. The purpose of this is to detect conceptual similarities, to

refine the differences between categories, and to discover patterns. The thematic map is then firmly defined.

### ***Deductive Thematic Analysis –OMMP (Orbach et al., 2003a)***

As previously discussed, thematic analysis was also undertaken deductively using the nine categories of OMMP (Orbach et al., 2003a). The entire data set was coded, similarly to process described above, using the theoretical, predefined coding scheme (see Appendix C.5).

## **3.5. Stage 2: Exploring Attitudes & Experiences of Clinicians**

### **i) Sampling & Data Collection**

Focus groups are chosen as a method of exploring clinicians' attitudes, and experiences in relation to assessing patients in A&E, as well as their thinking process in making decisions about care plans and treatments offered. Focus groups have been defined in different ways. Powell *et al.* (1996) define a focus group as a group of individuals selected and assembled by researchers to discuss and comment on, from personal experience, the topic that is the subject of the research. A key characteristic of this method is the insight and data produced by the interaction among participants that might not emerge with the use of other methods, for instance individual interviews (Webb and Kevern, 2001).

Focus group is thought to be the preferred methodology for this study in order to explore clinicians' experiences, thinking processes and judgements whilst providing a less threatening way of exploring clinical practice. This method allows for a multiplicity of views and emotional processes, and can explore both differences in opinions, and consensus in the group. Focus groups are particularly suited to the study of attitudes and experiences as they can offer a space to examine how knowledge, and more importantly, ideas, develop and operate within a given cultural context (Kitzinger, 1995). A particular strength of focus groups is the possibility for research participants to develop ideas collectively, bringing forward their own priorities and perspectives, to develop theories grounded in their experiences

(Smithson, 2000). One of the main limitations of the focus group methodology is though that the articulation of group norms and attitudes may silence individual voices of disagreement.

The sample is convenient and includes clinicians working in the Psychiatric Liaison Team. It is hoped that due to variations with regards to professional discipline (nurses, psychiatrists and psychiatry trainees), experience, gender and ethnicity, there is an opportunity to cover the spectrum of positions and perspectives in relation to the study's aims. Considering that the study is designed to gain an in-depth insight into clinicians' experiences and the process of decision making, it is decided to recruit a focus group large enough to generate a rich and in-depth discussion in which all participants could contribute. It is anticipated that the participants due to their lengthy experience as clinicians and the high level of involvement with this topic would have a lot to contribute and share (Morgan, 1997). SH and SI are complex phenomena. Therefore, it is decided to recruit a small number of participants.

The duration of each focus group is one hour and fifteen minutes to one hour and a half. On each occasion, a short fictionalised vignette is used. Bloor and Wood (2006, p.183) define vignettes as:

*'A technique used in structured and depth interviews as well as focus groups, providing sketches of fictional (or fictionalized) scenarios...Vignettes collect situated data on group values, group beliefs and group norms of behaviour... In depth interviews and focus groups, vignettes act as a stimulus to extended discussion of the scenario in question.'*

The most commonly reported limitation regarding vignettes is the relationship between the vignette and 'social reality', and more precisely between belief (what participants say they 'ought' to do) and action (what they 'actually' do) (Jenkins et al., 2010).

A short fictionalised vignette is provided in written format on both occasions (see Appendix C.6). The fictionalised vignettes portrayed assessments of patients presenting in A&E with SH and SI. The vignettes are designed based on psychosocial assessments, as plausibility is considered to be a critical factor in constructing vignettes. Scenarios that are viewed by participants as highly plausible are more likely to produce rich data on how participants interpret lived-experiences than those which invite astonishment, incredulity or disbelief (Jenkins et al., 2010).

They were amended in order to ensure confidentiality. Some information was removed and other information was added to increase the fidelity of the vignettes to real life patients and to address the aims of the study. The additional information included was guided by critical issues in the literature for instance, patients who represent to A&E and alcohol intoxication. Both of the vignettes were pretested and piloted with a convenient sample for clarity, accuracy and relevance. The sample consisted of clinicians working in child and adolescent mental health who undertake emergency psychosocial assessments in A&E routinely. That process led to minor amendments of the content of the vignettes.

The participants are invited to imagine, drawing on their own experiences how they would think and feel about the patients described in the vignettes, how they would make a decision about the care plan and which treatments the care plan would include. A question route (Krueger and Casey, 2009) is developed exploring the process of assessment, formulation and aftercare planning. The decision to devise a question route, instead of a topic guide, is primarily based on the fact that this is an area that has been previously researched in some regards. A question route is envisaged to facilitate some consistency between the two focus groups and allow some comparisons. The development of the question route is guided by the research questions (see Appendix C.7). Fielding and Thomas (2001) describe three levels of facilitation of focus groups: high, medium and low, each being distinguished by the level of control the facilitator has over the discussion who at all levels has a guiding role in the discussion, interjecting, asking questions and probing for further information when necessary.

On this occasion, the role of the facilitator can be described as medium level, whereby the groups are encouraged to consider key areas introduced by the question route and at the same time the groups are invited and allowed to pursue their own interests. It is anticipated that the groups may detour from the question route; therefore, there will be an attempt to distinguish between useful and helpful detouring versus diversions and distractions from the task. A 'funnel' approach is used; each group begins with a less structured approach which emphasises free discussion and subsequently moves on when required towards a more structured discussion of specific questions (Morgan, 1997). In an attempt to increase the

chances of being able to record the focus groups in a more accurate way, a co-facilitator is present. Whilst both the facilitator and co-facilitator have the advantage of being neutral to the organisation, they are unfamiliar with the organisational structure and procedures/policies.

All participants complete a short pre-focus group questionnaire, which gathers basic demographic information. An introductory statement is made in both of the groups which covers an overview of the topic, ground rules and an introductory question. The participants are invited to comment on the authenticity of the fictionalised vignettes. A reality check (Krueger and Casey, 2009) takes place at the end of the focus groups exploring the process of the group and potential improvements. All participants will be sent a post-focus group questionnaire which aims at gathering their experiences of the event, and a summary of the main findings for them to comment upon. The focus group process is audio-recorded and subsequently transcribed. Field notes are kept primarily in order to capture the group process and non-verbal communication (see Appendix C.8, for a sample).

## **ii) Analysis**

The data are analysed using a grounded theory orientated approach (Corbin and Strauss, 2008) in order to generate a conceptual framework. Considering that the focus group convenes on two occasions, there is an opportunity for concurrent data generation and analysis. The three main stages of grounded theory are followed to analyse the data as those are described by Corbin and Strauss (2008). First, the data are divided into smaller meaningful segments and then a descriptive or more conceptual in nature code is assigned to each segment. Axial coding then follows in which the codes are rethought of in terms of similarities' and differences. Similar codes are grouped together or merged in order to construct categories at a more conceptual level, or subdivided into more detailed ones (see Appendix C.9, for a sample of coding under the category emotional impact on clinicians). During that stage the fragmented data segments identified in the previous stage are brought together by exploring the relationships identified between the codes that represent them. In the final stage, the categories are used to review and re-examine the data to further elaborate the concepts analysed. Corbin and Strauss (2008) refer to the



process of integration in the final stage of analysis which they define as the process of linking categories around a core category (thematic groups), and refining and trimming the resulting conceptual construction (conceptual categories) (see Appendix C.10, for an example). Constant comparison procedures are followed, both within and between the meetings of the focus group.

This method is not able to offer an insight into the analysis of the group dynamics and the interactions among participants. Stevens (1996, p.172) proposed a series of questions researchers could ask with regards to group interaction when analysing data namely:

*'How closely did the group adhere to issues presented for discussion? Why, how and when were related issues brought up? What statements seemed to evoke conflict? What were the contradictions in the discussion? What common experiences were expressed? Were alliances formed among group members? Was a particular member or viewpoint silenced? Was a particular view dominant? How did the group resolve disagreements? What topics produced consensus? Whose interests were being represented in the group? How were emotions handled?'*

It is suggested that these questions help with understanding the group experiences and how interactions build on one another. The main critique of this approach is that the group interaction data would not be analysed systematically and might not be integrated with other data (Duggleby, 2005).

Using Stevens' (1996) framework, a code is assigned to each of the questions for example, the code 'common experiences' was used for the question 'What common experiences were expressed?'. As a result, the following coding scheme emerges: task orientated, contradictions, common experiences, alliances, silent members, dominant views, disagreements, processing disagreements, consensus and agreements, and emotions. The aforementioned coding scheme is deductively applied to the transcript; in this way the data analysis is incorporated into the transcript.

Rothwell (2010) refers to the work group culture and the emotional group culture in focus groups. She defined the work group culture as discussing the topic determined by the researcher (Rothwell, 2010). The emotional group cultures were suggested to refer to aspects of the group that affect the group's ability to collectively discuss the topic through their social interactions (Rothwell, 2010). With regards, to

describing emotional states in the focus groups, the Emotional Group Culture Categorization System is used (Rothwell et al., 2008) which is a coding system based on Bion's (1961) theory of group processes and influenced by the work of Stock and Thelen (1958). It was developed for analysing and incorporating group interaction data into the analysis. It includes the following codes: dependency statements, counter-dependency statements, fight statements, flight statements, flight-pairing statements, pairing statements, counter-pairing statements, and unscorable statements. The previously mentioned codes are used to code the transcripts, in order for the interactional data to be analysed by incorporating them into the transcript.

Conversation analysis and discursive psychology study everyday conversations and naturally occurring institutional interactions such as exchanges between doctors and patients (Potter, 1996; Westerman, 2011). Hence, they would not be an appropriate method of analysis in this study. However, in order to illustrate examples of how the themes identified are developed through talk and interaction, basic concepts from conversation analysis and discursive psychology are used such as adjacency pairs. An adjacency pair is a unit of conversation that contains an exchange of one turn each by two speakers and there is a preferred response (for example, acceptance or agreement) or a dis-preferred response (for example, rejection or disagreement) to each utterance (Potter, 1996). Adjacency pairs involve accounts that are the justifications behind the decisions, opinions and actions that participants express in the groups (Grønkjær et al., 2011). Whilst significant material such as time-taking or length of pauses are not taken into consideration, it is thought that attention given to speech and interaction would offer some insight into how the themes emerge through interaction without the use of conventional conversation analysis and discursive psychology (Barbour, 2007). The analysis is assisted by NVivo 9 software for qualitative analysis (QSR, 2010).

### **iii) Service-User Consultation**

Analysis and interpretation of results is a key research phase that can benefit from service-user involvement, as discussed in chapter 2 (Faulkner, 2011). Therefore, a consultation event, where service-users would be presented with key findings, and

would subsequently be asked to comment on the findings is organised. It is envisaged that service-users would share ideas and perspectives about the findings that are distinct from the student's. The aim is to form a consultation group of six to eight people with a history of SH or suicidality and presentation in A&E. The Mental Health Research Network is approached in order to recruit members from service users' forums. A group interview methodology is chosen for the consultation in which the group will be presented with three to four themes (key findings) that emerge in the focus groups with the clinicians of the Psychiatric Liaison Team. The discussion group is scheduled to last approximately 90 minutes. It is audio-recorded and subsequently transcribed into print. Considering that the aim of the consultation is to identify, analyse and report in detail themes regarding patients' opinions and experiences in relation to psychosocial assessments and their outcomes, thematic analysis is considered to be an appropriate method of analysis (Boyatzis, 1998). The method of thematic analysis was previously described (refer to 3.4.ii). The consultation is run with a co-facilitator who is a clinical psychologist working adolescents who SH. The analysis is assisted by NVivo 9 software for qualitative analysis (QSR, 2010).

### **3.6. Integration**

A common and simple approach to integration is to bring the findings from different methods together, comparing and contrasting them to see if further understanding can be gained (Brannen, 2005; O'Cathain, 2010; Teddlie and Tashakkori, 2009). An assumption of convergence is not required, and apparent contradictions between findings may lead to further valuable insights about the issue under study (Fielding and Fielding, 1986). This approach is followed in this study; data sets are initially analysed in relation to the particular research questions of each phase/stage and in the concluding chapter, findings and insights from the different phases will be discussed.

Creswell and Plano Clark (2011) discuss three approaches in integrating data namely, merging data, connecting data, and embedding data. In this study the

concept of connecting data appears relevant as the analysis of one data set (for example, thematic analysis of psychosocial assessments) informs the subsequent data collection (focus groups). In this way, integration occurs by connecting the results from the initial qualitative phase with the data collection from the second qualitative phase (Creswell and Plano Clark, 2011). Integration also occurred at the sampling stage of the qualitative study as key variables and main findings of the quantitative study are used, to some extent, to identify the sample of psychosocial assessments included for the qualitative analysis. Thus, the concept of embedding data is relevant as it refers to a secondary dataset being embedded within a larger study design.

### **3.7. Quality of the Study**

This section refers to quality criteria for qualitative research methods only. There has been considerable debate over whether it is possible to judge qualitative research by using conventional criteria such as generalisability, reliability and internal validity (Maxwell, 2002). There have been primarily two approaches to address this issue, namely to develop alternative criteria for qualitative research, and to adapt traditional criteria. The term credibility is chosen for this study which indicates that findings are trustworthy and believable in that they reflect participants' and researchers' experiences with a phenomenon but at the same time the explanation is only one of many possible plausible interpretations from the data (Corbin and Strauss, 2008). A few other traditional criteria, such as triangulation and generalisability will be discussed.

In order to ensure credibility some steps are taken. Firstly, the research process is described in this chapter in detail. The epistemological and theoretical stances that have influenced this study are described in this chapter but also in the introduction. Long extracts of the data will be presented in the following chapters. A common critique of reporting qualitative research is that the data presented are selectively chosen to support conclusions drawn by the author or to further an agenda of some kind (Guest et al., 2012). Thus, attention will be given to 'negative'

cases (elements of the data that seem to contradict or differ from the emerging explanatory scheme) (Mays and Pope, 2000).

'Members checking' or 'respondent validity' entails participants themselves reviewing the summarised data to see if they accurately reflect their intents and meanings (Guest et al., 2012). The participants of the focus groups and the service-users who attend the consultation will be sent a summary of the findings and then invited to offer their comments and reflections verbally or in writing, and they may do so anonymously if they wish (validation of findings process). As previously mentioned, participants' thoughts on the authenticity of the vignettes are sought.

Inter-coder agreement or inter-rater reliability is probably the most commonly discussed element of quality in qualitative studies. Two or more researchers, using the same codebook, independently apply codes to a section of a text or a transcript and their codes are then compared to explore agreement. There have been multiple variations as to how inter-coder agreement is conducted and various ways to assess agreement (Guest et al., 2012). Whilst formal inter-coder agreement processes are not followed in this study, seminar groups are used to explore different ideas about coding. Two psychosocial assessments are provided to members attending a seminar group as well as the codebook and the members are asked to code them independently. Coding is then compared, qualitatively, and discussed. Kappa coefficient is not used to provide a measure of agreement. Finally, primary and secondary coding will take place by reviewing my own coding after some time passed since the first round of coding.

Triangulation refers to combining multiple theories, methods, observers and empirical material to produce a comprehensive representation of the object of the study (Silverman, 2011). Triangulation in this study involves combining data that produced by different samples and methods of analysis. It is hoped that by drawing data from different sources and using different methods that have different methodological limitations, it may be possible to increase the quality of the findings. Triangulation is used to produce complementary data, and a fuller and more complete picture of the phenomenon concerned.

Generalizability in qualitative research is best thought of as a matter of the 'fit' between the situation studied and others to which one may be interested in applying

the concepts and the findings of the study (Schofield, 2002). Silverman (2011) suggests that qualitative researchers are more interested in generalising processes. In this study, the sample of the psychosocial assessments is chosen carefully to include a wide range of situations including 'deviant cases' in order to maximise variation and to capture the heterogeneity of the people who SH or experience SI. Whilst the sample of the focus groups is drawn from only one site, the team from which is drawn is considered to be similar to the Psychiatric Liaison Teams existing in other hospitals. It is, therefore, hoped that the data gathered are meaningful beyond the particular cases and sites studied.

In summary, various steps are taken in order to ensure the quality of data collection and analysis in the current study and further discussion will take place in the subsequent chapters as the findings will be presented.

### **3.8. A Note on Reflexivity**

Corbin and Strauss (2008) suggest that a researcher has feelings and sensitivity for the topic, the participants and for the research and that in order for a researcher to do good analysis one has to be able to step into the shoes of the participants, otherwise the richness and depth of data is lost. Nevertheless, from a different viewpoint this constitutes a disadvantage of qualitative research for some. Various types of reflexivity have been reported in the literature namely, personal, functional, descriptive and analytical, epistemological, and methodological. A common factor in most definitions is that reflexivity involves engaging in an on-going process of reflecting (Finlay and Gough, 2003). For the purposes of this chapter, the researcher's/ student's position is thought during the different stages of this study. Nevertheless, the thoughts discussed are not the only aspects probably worthy of attention but some.

I came to this study as a social work student and clinician who was initially rarely involved in psychosocial assessments in A&E; however, that soon changed and I too undertake psychosocial assessments in A&E. Whilst I was very interested in the therapeutic work with adolescents who SH, I initially found the need to make

rapid decisions when undertaking A&E psychosocial assessments for adolescents presenting with SH somewhat anxiety provoking particularly when these were undertaken out of office hours when it is not possible to liaise with other agencies. Furthermore, through my own experience of conducting A&E psychosocial assessments for young people with SH and reviewing relevant literature from various disciplines, I came to see SH as a complex phenomenon influenced by various parameters (psychological, family, social/ environmental and sometimes biological factors) and that not one theory could offer a way of understanding every patient presenting in A&E. Thus, my pre-existing relationship with the topic was primarily as a clinician working in child and adolescent mental health services. I also held the belief that adult patients were treated differently- less favourable compared to children in A&E. Larkin *et al.* (2006) use the concept of 'persons in context' referring to researches being actively engaging in and inseparable from the world and therefore, implying that research is influenced by personal and professional variables.

The data set of the approximately 61 psychosocial assessments were an exceptionally rich source which though referred to complex histories of patients experiencing pain, losses, anger and isolation/loneliness usually in the context of social and environmental stressors. Not every psychosocial assessment evokes a strong reaction in me and/or alliances with the patients or the clinicians or both; however, some do and I partly tried to address/connect with my emotional state by collecting the data slowly and over a period of several months so as to allow time to digest what was in front of me. The collection of data through focus groups as well as the consultation with the service-users revealed various issues related to the interaction between the participants and the student. During the focus groups with the clinicians, I sometimes found myself being preoccupied with how to be a good referee between doctors and nurses as opposed to be fully immersed in the data collection. It was partly that experience that led me to consider essential to analyse the interactional data alongside methodological issues.

The consultation with the service-users was a very important part in this study and offered alternatives -to my- narratives with regards to understanding the data collected through the focus groups. The process of the consultation was equally

interesting. Some service-users wished to occasionally take control of or guide the interview by sometimes treating me/ placing me in the role of the benign and ignorant student that they needed to educate and help understand. There were though occasions, particularly in the beginning of the consultation, when considering perhaps my professional role, I was thought to be somebody who was not going to 'listen' or to be interested in their emotional experiences similarly to the professionals they had been involved with. Whilst it was possible to remain in the inquisitive and curious researcher's position, it was also tempting to respond as a clinician on some occasions. Having a co-facilitator in the focus groups and the consultation with the service-users helped tremendously with running the events but also with jointly trying to make sense of those.

Throughout the data analysis there was an attempt to remain as close to the data as possibly in an attempt to not impose my ideas and preoccupations on the data. However, similarly to the other research phases, the attempt to make sense of the psychosocial assessments, the clinicians' accounts and the service users' views was influenced by the context and my previous experiences, identity, motivations, and beliefs. Nevertheless, those beliefs were not static but changing during the study. This in conjunction with preliminary research findings led to changes in the original research design, data collection, and subsequently analysis. Therefore, ultimately it was felt that I both influence and was influenced by the research process.

It is suggested that there is no way of avoiding or controlling for observer bias in qualitative research (Churchill, 2003) and, therefore, it is considered important for a researcher to remain aware of his/her own assumptions (Corbin and Strauss, 2008). Memos in NVivo (QSR, 2010) are used in order to capture some thoughts about the management of each phase of the study, the issues and tensions arising, and the ways I dealt with these, which helps me to recognise some of the influences I have upon the research (such as analysis of interactions in the focus groups).

In summary, my interests, experiences and interpretations have influenced the research process. Whilst it can be argued that this has introduced bias in the process of collecting and analysing the data, others think that the challenge is not to eliminate bias but to use it as a focus for more intense insight (Frank, 1997). It is



acknowledged that it has been very difficult to separate the student/researcher and clinician identity throughout this study, and in turn, the research process has constantly been influencing my clinical work.

### **3.9. Ethical Considerations**

A favourable opinion was received from the NHS research ethics committee (see Appendix C.11). The three main areas related to ethical issues in research include informed consent, privacy and confidentiality and the consequences of the interview/harm. Written consent is obtained at the start of the focus group and participants are informed that they are under no obligation to participate and that they may withdraw from the study at any point (see Appendices C.12 and C.13). The vignettes include no identifiable patient information. The participants of the focus group and the consultation event are not approached directly but through their manager/consultation group co-ordinator, which may have reduced or increased the pressure to participate. Confidentiality is assured both in relation to the participants and to the collected textual data (psychosocial assessments). Nevertheless, it is recognised that focus groups cannot always be fully confidential or anonymous, because the material is shared with the others in the group. Therefore, commitment of confidentiality is sought from those who participated.

The data are collected and stored in a way that ensured confidentiality. Throughout the dataset names are removed and all documents are stored electronically and password protected. The consequences of involvement in the study are difficult to measure. Some of the participants in the focus group said that the focus group discussions had made them think about their work in ways they had not before. It is not anticipated that this study would be likely to cause harm to the participants; however, arrangements have been made in the event that would occur. Whilst the consultation event with the service-users does not constitute research, the same principles apply.

### **3.10. Summary**

This chapter has discussed the methodology to be applied in this study. The main findings will be explored in the subsequent four chapters. This study attempted to remain close to the data and therefore, there will be an attempt to report in detail the generation of themes and categories. Firstly, the findings of the psychosocial assessments will be discussed in the next two chapters (chapters 4 and 5), in which episodes of SH and SI will be presented and compared with regards to various parameters. Clinicians' experiences, attitudes and decision-making as these emerge in the focus groups will be discussed in chapter 6. Finally, the consultation event with the service-users, which enhances the analysis of the data gathered through the focus groups, will be presented in chapter 7.

## **Chapter 4- Findings from Psychosocial Assessments: characteristics, similarities & differences**

### **4. Introduction**

This and the following chapter will focus on the findings from the psychosocial assessments. The socio-demographic factors and the presenting problems of the sample are briefly presented. Patients' stories as those were described in the psychosocial assessments with regards to the following conceptual categories: ill health (physical and mental health), environmental stressors (accommodation, employment, finances), relating to others, significant childhood and adulthood experiences will be discussed comparing SH presentations with presentations with SI. The findings of the application of the nine categories of the Mental Pain Scale (Orbach et al., 2003a) to the two groups of attendances will be presented.

Excerpts from the data will be presented and will appear in quotation marks following by their source of origin (for instance, SH 84.02), as illustrative examples of the analysis. It is suggested that one exemplar quote is used to illustrate each overarching theme presented (Guest et al., 2012). Considering that some conceptual categories are complex and multidimensional, two or more quotes per theme will be presented here. In addition, tables are used to summarise and simplify the characteristics and themes generated from the data.

#### **4.1. Patient Socio-demographic Characteristics at the Index Episode.**

Eighteen females and twenty-two males, aged between 18 and 71 years (mean age 39.65) were assessed (a summary of the demographic data are presented in Appendix D.1). The majority of patients were White. Ethnic groups other than White included Black and Asian. Fourteen patients were married or in a relationship, five patients were divorced or separated, and two patients were widowed. Seven patients were single and not in a relationship. The vast majority of patients (33) did not have

childcare responsibilities. Most patients were living in their own flats/houses (23). Only six patients were in paid employment. More than half of the patients (24) had previously self-harmed.

Patients reported having engaged in a variety of self-harming behaviours (see Appendix D.2) with self-poisoning being the most frequent method of SH in the past. Out of the twenty patients who initially presented with SI, three patients represented with further thoughts of suicide and three patients represented with an episode of SH. Similarly, out of the twenty patients who initially presented with SH, three patients represented with repeated SH and one patient represented with SI.

## **4.2. Presenting Problem**

### **i) Episodes of Suicidal Ideation**

Twenty-nine presentations with SI were studied in total (see Appendix D.3). Those episodes related to twenty-one patients. Twenty patients presented with SI at the index episode and one patient had previously attended with an episode of SH during the study period. Three presentations resulted from a threat of suicide namely jumping into the Thames, jumping from height, cutting throat. In describing the remaining presentations, the categories suggested by Bebbington *et al.* (2010) are used, namely tiredness with life, death wishes and suicidal thinking. Firstly, no attendance was related to tiredness with life. Three attendances were related to death wishes. Two presentations involved both death wishes and suicidal thinking. Finally, suicidal thinking resulted in the majority of the presentations (21). The London Ambulance Service (LAS) was the most common way of arriving at the A&E (14 attendances).

### **ii) Episodes of Self-harm**

Thirty-two presentations with an episode of SH were studied in total (see Appendix D.4). Those presentations related to twenty-three patients. Twenty patients presented with SH at the index episode and the remaining three patients had

previously attended with an episode of SI during the study period. The most commonly used method of SH was self-poisoning (15 attendances). The substances ingested in overdoses were the following: prescribed medication, pure paracetamol, ibuprofen, diphenhydramine and white spirit. The precise ingested substances were not explicitly stated on five presentations. The LAS was the most common route (18) to A&E.

#### **4.3. Similarities in Biopsychosocial Stressors in Presentations with Suicidal Ideation & Self-harm**

The thematic analysis of the content of the psychosocial assessments led to the development of four conceptual categories, which appeared consistently in both clusters of presentations. The similarities emerged for both clusters of presentations in conceptual categories will now be presented (table 1 summarises the three level analysis).

##### **i) Relating to Others**

The thematic groups that form this category are as follows: relating to partners, estrangement from family, and relating to friends. Five assessments of patients experiencing SI and ten assessments undertaken following an episode of SH indicated difficulties in the patients' relationship with their partners. The nature and the degree of marital/couple difficulties varied. However, all patients appeared to be distraught by those difficulties. For instance, the assessment of a female suicidal patient, who had recently had a miscarriage, noted that she recalled feeling very lonely, abandoned, and blamed for the baby's death by her partner. A male suicidal patient, presenting once with thoughts of taking an overdose, experienced sexual dysfunction secondary to antipsychotic medication. He described that as the cause of his marital disharmony, which was causing him distress and emotional pain.

**Table 1. Presentations with SI & SH: Similarities in themes emerged in the analysis**

<b>Level 1: Conceptual Categories</b>	<b>Level 2: Thematic Groups</b>	<b>Level 3: Thematic Categories</b>
Environmental Factors		
	Accommodation	
		Living in Hostels- Difficulties
	Employment	
		Being off sick
		Employment difficulties
		Loss of employment
	Finances	
		Financial Hardship
		Financial Loss
	Transitions	
Ill Health		
	Mental Illness	
		Psychiatric Diagnosis
		Symptoms of Mental Illness
	Physical Illness	
		Long-term Illness
		Physical Symptoms
Relating to Others		
	Family	
		Estrangement from parents
	Friends	
		Loss of friends
		Support
	Partners	
		Separation
		Marital difficulties
		Impact on spouses
Significant Experiences		
	Childhood Experiences	
		Abuse/ neglect
		Parental mental illness
	Adulthood Experiences	
		Death
		Separation- feeling rejected
		Abuse /harassment

A patient presented in A&E with superficial lacerations on four occasions following arguments or lack of contact with her boyfriend. A young female who presented once and had a history of sexual abuse was profoundly preoccupied and distressed with thoughts about her partner's fidelity. The clinician wrote:

*'...(patient's name) says she lay awake much of last night, with preoccupation about her relationship with her partner. She doubts his fidelity and has been repeatedly accusing him of having a sexual relationship with ?her cousin recently [...(partner's name) interjects that he is exhausted with defending himself repeatedly on this theme]'. (SI 486.0)*

This assessment also described the partner's exhaustion by the patient's repeated doubts about his fidelity; the clinician considered that in the process of the aftercare planning. Another SH assessment involved the patient's spouse who described the deterioration in the couple's relationship as a consequence of the mental health difficulties of the patient. Two SI assessments involved the patients' spouses. Both assessments discussed the spouses' emotional and physical exhaustion from looking after their mentally ill partner. One assessment noted:

*'Husband has been watching her closely and feels that they have both been under stress. Called LAS this am, as felt he could not cope with keeping an eye on her anymore...He would like support in caring for her, as feels 'drained from trying to watch her' all the time'.* (SI 380.0)

From this assessment, it seemed that the patient and her husband had interrelated difficulties, which were affecting each other; the patient was acutely worried about her husband's drinking and her husband felt exhausted by his caring role.

Three SI and eight SH psychosocial assessments found estranged relationships between the patient and his/ her birth family. Although some assessments did not explore those difficulties in detail, the assessment of a patient who initially presented with SI and then with SH indicated that the lack of contact with family members had been causing unbearable distress, sadness and frustration to the patient.

Two assessments sought the views of family members; one of those assessments involved the mother of a young patient who had presented with an overdose. The clinician had noted that the mother was hostile and did not wish to engage in the assessment. From the clinician's account the mother had reported that her relationship with her *'daughter had its ups and downs'* (SH 403.0) with no further information. A psychiatrist assessing an elderly lady with suspected organic psychosis who had jumped into the Thames, had contacted the patient's cousin who had confirmed ruptures in their relationship.

With regards to friendships and social relationships, one suicidal patient presenting once had lost all of his friends following a head injury and subsequent changes in his mood and behaviour, and six SH assessments showed difficulties in forming or sustaining relationships. Six SI assessments and seven SH assessments identified stable and helpful relationships with friends.

## ii) Environmental Factors

This conceptual category consists of four thematic groups, namely employment, accommodation, finances and transitions/relocation all of which will be discussed below. Approximately one third of the assessments (10) in each cluster explored employment related issues, namely difficulties with current employment, being off-sick and unemployment. Employment related issues were primarily related to difficulties in the patients' relationships with colleagues/ managers. A male patient, who attended with a single SI episode, was working as an academic. He appeared to have been involved in a serious and enduring discord with a colleague. Furthermore, he had intrusive thoughts about his colleagues discussing that discord. He was very fearful that he had been excluded from the discussions. While the patient was profoundly preoccupied by that (ruminating) and found that experience painful, the exact impact of the aforementioned difficulties on his work/ productivity was not clear.

Two female patients presenting with a single episode of SI reported being off-sick for different reasons. While one patient was unable to work due to physical health problems, the other patient who worked as an army nurse, was signed-off sick due to a depressive disorder and work-related stressors which she had found unbearable to cope with. Her assessment noted

*'She dislikes the location and her boss who is a Major is mean to her. She feels that he does not like her and all his about her are negative. He always put her down, makes her feel bad.'* (SI 17.0)

Two SH assessments involved patients who were unable to work due to either physical health related problems or mental illness. The assessment of one of these patients, who worked as a social worker, indicated that she would be retuning to work soon. The thought of returning to work was causing her profound anxieties. The clinician noted

*'Due to start back at work this week. Found the thought hard. Never confided in her husband about her difficulties at work'.* (SH 21.0)

Similarly, one of the assessments of a patient who presented with repeated SH discussed the patient's difficulties in functioning with every day work related tasks. Hence, a recommendation was made for the patient to be signed off work. She



appeared to be in an emotional turmoil, distress and sadness further to her separation from her boyfriend and other events, which she had experienced as abandonment. There was some controversy over her diagnosis.

As for unemployment, one SI assessment and three SH assessments underlined the patients' concerted efforts to find employment to no avail. One of these patients presenting with SH narrated a story about having been kidnapped from East Europe and brought to the UK to work in a farm. He reportedly managed to escape but was unable to find employment. The psychiatrist undertaken this assessment summarised his difficulties as follows:

*'Unable to access work or money- has been begging in street (I am not a thief)'. (SH 453.0)*

Three SH assessments noted the patients' recent loss of jobs without discussing the implications of those events. Three SI assessments explored the circumstances that had led to the patients becoming unemployed namely, alcohol related difficulties and an incident when the patient had gone on a holiday without the approval of his employer which resulted in dismissal.

Difficulties with accommodation and housing were identified in ten SI assessments and eight SH assessments. Those difficulties related to patients' being homeless and difficulties with other residents/ neighbours. Six SI assessments and six SH assessments involved patients who were homeless. Two patients presenting with SH had left their homes on their own will and became homeless; both of those patients presented with symptoms of mental illness and the onset of those difficulties coincided with their decision to leave their house. The nurse conducting the assessment wrote:

*'Following long period of stability, has left his job and home, and sleeping rough...has been sleeping rough in London, occasionally staying in night shelters. Gave away his belongings to charity shops. Sleeps well; has his own pitch near the Strand where he sleeps. Uses soups-runs and homeless services. However, fearful of crowds and of some other rough-sleepers who behave aggressively'. (SH 345.0)*

Three SI assessments described the patients' difficulties in relating to other residents/ neighbours, one of which referred to a depressed patient who was using alcohol recurrently and appeared to be intensively preoccupied with an interaction he had with one of the hostel's residents.

*'A female resident told him that there was a knife in his room. ...(patient's name) was worried about that as due to his contract with the hostel, he should not have any weapons. He could not recall having a knife in his room and felt confused...He feels angry and frustrated with the female resident and had an urge to kill her'. (SI 23.1)*

Two SH assessments discussed stressors related to the current accommodation (being unhappy in current location and living in a Bed and Breakfast Hostel provided by a local authority).

As for finances, five SI assessments and eleven SH assessments of patients, reported financial hardship and debts. One SI assessment showed the patient's sense of humiliation and entrapment as a result of financial losses, which he had explicitly linked to his marital problems and his alcohol dependence. It ought though to be noted that the respected patient did not appear to report suffering from financial hardship. One of those patients' suicidality was thought to be directly associated with her financial difficulties:

*'(patient's name) reports to be in crisis for several weeks which runs in conjunction with her having on-going problems in relation to her benefits...Over the last six months appears to have had a crisis admission to Ruskin Ward with increased following an overdose which was directly related to problems she was having with the DWP...Appears to be in crisis since June owing to ongoing problems with her benefits and various disputes with DWP.' (SH 276.0)*

Most of these patients perceived their financial problems to be insoluble.

Finally, seven individuals, who presented once with SI and seven individuals who presented once with SH had experienced a major life transition and relocated themselves to the UK. The majority of these patients were originally from Africa and appeared reasonably settled in the UK. A young asylum seeker from Iran found it very difficult to access appropriate accommodation and medical treatment which was contributing to his low mood alongside other emotional difficulties. He had been imprisoned in Iran as reportedly was socialising with a girlfriend in public during the month of Ramadan and was subsequently tortured. One patient with SH was making concerted efforts for repatriation which were not successful. In addition, one patient who had recently moved to the UK from Uganda in order to study appeared to struggle to adjust to the climate. The clinician wrote:

*'dislikes the long, dark and cold nights in UK. Feels that he has been more self-isolating because of this...Finds dark nights in the UK seem longer.' (SH 454.0)*

### iii) Ill Health

The conceptual category of ill health comprises the thematic groups of mental illness and physical illness. The thematic group of mental illness includes the thematic category of psychiatric diagnosis and that of symptoms of mental illness (without a clearly indicated diagnosis in the psychosocial assessment). A clearly recorded *psychiatric diagnosis or comorbid diagnoses* were evident in thirteen psychosocial assessments following SI and nineteen SH assessments. The classification of the diagnosis is as per the ICD-10 (WHO, 1994).

Mood disorders were the most common diagnosis in both clusters of presentations (table 2 shows the psychiatric diagnoses as recorded in the assessments). Psychotic episodes were rare in both clusters but emotional distress was associated with those in the patients who experienced psychotic symptoms. The assessment of a female patient with SI with and an emerging psychotic episode described the impact of the profound hallucinations on the young patient:

*'She presented as very anxious and difficult to engage stating that she wasn't allowed to talk as she be punished. States that since July she had people visiting her who she can see. She doesn't know who these people are or why they have come. They have become more disturbing and interfering steadily over the past 3 months but she has never told anyone until today'. (SI 370.0)*

**Table 2. Thematic Category: Psychiatric diagnosis**

ICD-10 <sup>3</sup>	Psychiatric Disorder	No of times a theme was coded in the total sample	No of times a theme was coded in the assessments of Suicidal Ideation	No of times a theme was coded in the assessments of Self-harm
F00-F09	Organic mental disorders	2	1	1
F10-F19	Mental and behavioural disorders due to psychoactive substance use	6	5	1
F20-F29	Schizophrenia, schizotypal and delusional disorders	2	1	1
F30-F39	Mood [affective] disorders	14	7	7
F40-F49	Neurotic, stress-related and somatoform disorders	2	1	1
F60-F69	Disorders of adult personality and behaviour	7	0	7
F70-F79	Mental retardation	4	0	4

<sup>3</sup> WHO (1994)

Personality disorders were only found in the psychosocial assessments of patients with SH. Disorders related to abuse of alcohol and recurrent use of alcohol were found in both clusters of presentations; however, they were by far more common in people presenting with SI. Learning Disability was only found in the presentations with SH and referred to a female patient who presented with SH on four occasions.

The process of attempting to reach a diagnostic conclusion was described in one of the assessments of a young female patient, who attended twice with SH. There was a sense that the clinician was making concerted efforts to make a decision. She had received a diagnosis of depression and personality disorder. During the assessment, symptoms of Post Traumatic Stress Disorder (PTSD) were identified (flashbacks and dissociative states). The clinician reflected upon his disagreement with the patient's psychiatrist regarding the diagnostic formulation.

*'She had been diagnosed as:*

*Bipolar 2 depression;*

*Depression Personality Disorder of borderline Trait...*

*Most of the self-harm behaviour and state of mood at the time of self-harm were more of Dissociated state rather than in the severe depressive moods. I do not see the clear evidence of Bipolar II symptoms but rather Depersonalisation and derealisation with the dissociated states. With the symptoms of Flashback, Nightmares with dissociated state accompanied by Self harm I am more of in favour of PTSD.'* (SH 59.2)

While a diagnostic formulation was not stated, clinically significant symptoms of *mental illness or comorbid mental illnesses* were illustrated in fourteen assessments with SI and six SH assessments (table 3 shows clinically significant signs of mental illness found in the psychosocial assessments).

In the assessment of a male patient with SH, a complex interrelated pattern emerged in which his recurrent use of alcohol was both associated and resulting in loss of his marriage. Interestingly, the patient in the course of the assessment started developing some insight:

*'He has resumed drinking in last 4 months since end of his marriage. Had been abstinent for 18 months, after realising his health was at risk...Home trader making money enough to live on. However, when drinking escalated in 2005 he began to be intoxicated during the day and made rash decisions and trades. Lost 80% of his savings and liquidity. Was drinking in the am to avoid withdrawal. Dependent pattern.*

*He has returned to his pattern recently...his beginning to realise that many of his difficulties are the result of indulgence in alcohol'. (SH 84.0)*

**Table 3. Thematic Category: Symptoms of psychiatric disorders**

ICD-10 <sup>4</sup>	Psychiatric disorder	No of times a theme was coded in the total sample	No of times a theme was coded in the presentations with Suicidal Ideation	No of times a theme was coded in the presentations with Self-harm
F00-F09	Organic mental disorders	1	1	0
F10-F19	Mental and behavioural disorders due to psychoactive substance use	10	8	2
F30-F39	Mood [affective] disorders	7	5	2
F40-F49	Neurotic, stress-related and somatoform disorders	2	1	1
F60-F69	Disorders of adult personality and behaviour	1	0	1
F70-F79	Mental retardation	1	0	1

Two SH and four SH psychosocial assessments had collected information about the patient's mental state from spouses and relatives all of whom had expressed concerns about the deterioration in the patients' mental state.

In the thematic group of physical illness, the categories of long-term illness and physical symptoms emerged. A physical illness was identified in six SI assessments (HIV, cancer, sickle cell anaemia, epilepsy, heart disease and asthma, lymphangioma) and seven SH assessments (thyroid disorder, asthma, hypertension, diabetes, kidney problems, suspected hernia).

The assessment of a patient with SI who presented as depressed and relatively isolated identified that he was not seeking treatment for lymphangioma which could be thought of as self-harm by omission (Turp, 2002). The clinician noted *'When questioned about why he had not sought treatment for the lymphangioma, R... said that he had not had the time, and he was not bothered if I (he) get cancer'*. (SI 20.0)

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<sup>4</sup> WHO (1994)

A very distressed female elderly patient with SH had recently undergone surgery for thyroid disorder which might have been the potential aetiology of an assortment of psychotic symptoms she was presenting with.

*'...Describes...(patient's name) as crazy since recent surgery (?thyroidectomy). \*Stated Mrs (patient's name) threatened to kill her. Reportedly contacts cousin's friends late at night. \*Reportedly leaves home and sleeps in park...From cousin's account, diagnosis in behaviour coincides with thyroid operation resulting in ?organic psychosis/affective component.'* (SH 148.0)

With regards to the patients who did not have a diagnosed physical illness, a male patient presenting with SI who had been tortured whilst in prison reported feeling pain in his back as well as his head. He reported being unable to access the required treatment (physiotherapy) which as previously mentioned was contributing to his depressive mood. A female patient, who attended once with SI, reported a history of severe pain in her head and neck, which was impinging on her emotional state and activities of daily living. The patient appeared to be very distressed by her symptoms but despite various investigations, no medical cause had been identified. The clinician noted:

*'Reported to feel distressed by headaches...In interview (patient's name)' main concern were her headaches and impact on her life. She gave a 5 year account of problems and said that she has had investigations in the past'.* (SI 312.0)

Similarly, a patient presenting with SH experienced psychosomatic symptoms-recurrent abdominal pain following long arguments with his wife. No medical explanation had been found to account for that.

#### **iv) Significant Childhood & Adulthood Experiences**

This conceptual category is formed by two thematic groups namely significant childhood and adulthood experiences, and mostly refers to losses patients' shared with the clinicians.

With regards to childhood experiences, three SI assessments and six assessments of SH referred to sexual abuse or neglect during childhood. A young female patient presenting on two occasions with SI discussed her experiences of having witnessed her father raping her best friend and being taken in care. A patient with SH who was sexually abused by her father shared with the clinician her

unresolved state of mind following that incident despite the presence of some mediating factors, such as a supportive partner and treatment.

*'Says she has been preoccupied for many years by experiences of sexual abuse in her childhood...She was feeling dirty and unworthy , that she is a weirdo who will never overcome her past history of abuse'. (SH 486.0)*

Those traumatic experiences might have been further triggered by the birth of the patient's own child. A SH assessment that indicated childhood experiences of emotional neglect stated:

*'Reports disordered eating at boarding school aged 12-15 years old (refusing to eat), as parents had previously forced him to eat everything on his plate, so relish freedom to control/refuse food. ...Reports unhappy childhood. Also forced to eat all food on plate, same meal every day, leading to disordered eating'. (SH 345.0)*

Sexual abuse by peers was reported by a patient presenting twice with SH. One patient presenting with SI and one patient presenting twice with SH referred to their parents' mental illness one of whom referred to low levels of perceived parental warmth and a strong wish for reconciliation.

As for experiences during adulthood, twelve SI and twelve SH assessments referred to losses during adulthood namely, death of partner or family member, separation from partner, abuse and harassment. The assessment of a patient presenting with SI described his distress associated with the death of his mother from cancer. The circumstances of her death and prior treatment were not explored; however, parental loss appeared to coincide with the onset of the deterioration in the patient's psychosocial functioning.

*'Following death of mother drinking and use of cocaine have escalated as has offending behaviour, mainly crimes of acquisition...Father was alive and well one younger brother and one younger sister. Poor relationships with family since his Mother's death'. (SI 464.1)*

A young female patient who presented on two occasions with SH shared her wish to terminate her relationship. She appeared to feel deeply betrayed by her ex-fiancé due to the fact he had been involved in financial mismanagement of funds for a church choir they were both involved in. The assessment of a patient presenting with attempt to hang himself showed his insight into what might have led to the couple's difficulties and eventual separation.

*'he spent all the money before Christmas, gambling. His partner told him to leave at this point and he has been sleeping outside the flat in his car for the last 7 nights...His Gambling has been a factor and a stressor throughout his relationship with his partner they have split up many times because of this and he feels this was the final straw'. (SH 450.0)*

The assessment of a homosexual male presenting with SH noted intimate partner violence; nevertheless, it was uncertain whether he remained in that relationship or not. The same patient shared with the clinician that he had sexual intercourse with the husband of his aunt and was subsequently deeply troubled and preoccupied by that. The clinician noted:

*'His aunt's husband approached him and solicited sex from him on three different occasions. He reports to now feel bad about the encounters and feels that he is not able to bring this matter up. He reports to be struggling with why he consented to the solicitations.'* (SH 49.0)

The assessment of a male patient, who presented with a single episode of SI, discussed the patient's experience of having being imprisoned in his own country and tortured by the police and staff members of the prison. Whilst there was no indication of how the patient was feeling in relation to his experiences of being tortured and separated from his family, the clinician was thinking that an assessment for suspected PTSD would be prudent. On a related note, the assessment of a female patient with a history of being taken into care reported experiences of being constantly threatened with physical violence by her neighbours.

*'...(patient's name) claimed that there is a gang of people who are threatening to kill her*

*-and are hassling her in her home...*

*She informs me that she is currently medium risk of harm from others*

*-but needs to be "high risk" before she will receive help in relocating...*

*Of this evenings incident... she states that*

*'if she is not going to get any help and people are threatening to kill her then she may as well kill herself'.* (SI 213.2)

In general, while a number of losses were recorded in these assessments, it was not often clear how the patients made sense of those and how those were currently affecting them.



#### **4.4. Main Differences in the Biopsychosocial Stressors in Presentations with Suicidal Ideation & Self-harm**

The main differences between the two clusters of presentations referred to support by partners, difficulties in family relationships (but not estrangement) and diagnosis. Only two patients presenting with a single episode of SI felt supported by their partners. One of these assessments noted the patient's worries about the impact of his mental illness on his marriage and his feelings of inadequacy:

*'He has concerns for the future of their marriage especially as his wife has had to support him through his difficulties at work. He reported that she is a special woman and she needs a special man and that in 2004 he felt like that person for a while but not now'.* (SI 16.0)

None of the patients presenting with SH reported having a supportive partner. Whilst the clinician conducting a SH assessment concluded that the patient's husband-a senior clinical psychologist, was supportive, the patient herself had referred to difficulties in her relationship with her husband.

Difficulties in the relationships between the patients and family members were more often found in SH than SI. The assessments of a young female patient who presented on two occasions made reference to the turbulent relationship between the patient and her family. One of the two assessments offered a discourse about this; it was reported that the patient was deeply upset and angry with her Mother who had decided to not inform her of the grandmother's death for a few days in an attempt to not disrupt her daughter's working life. There was a sense that the patient was mostly preoccupied by her Mother's actions and the loss of the grandmother appeared to be a peripheral issue. From the way the assessment was written, there was a sense that the patient struggled to make sense and show any mentalisation regarding her Mother's decision. Furthermore, while the assessment of a male patient presenting with a single episode made no reference to current difficulties, it was highlighted that the patient had

*'physically assaulted his mother when she was pregnant as he was angry about her pregnancy'.* (SH 49.0)

The assessment of a male patient of Pakistani origin discussed his on-going difficulties in his relationship with his Mother in law and her sister who seemed to

have been closely involved in the couple's relationship and made decisions about the future of the marriage. He seemed to strongly think that his masculinity was undermined which was causing him tension; nevertheless, he felt disempowered to address those difficulties. Finally, the assessment of a female patient who was married and had two children made reference to '*difficulties in the family*' without any further discourse. However, her parents were noted to be highly involved in the care of her children. Only two assessments pointed out that the patients had a supportive family.

A diagnosis of personality disorder was most commonly found in the presentations with SH (Hawton et al., 2013b). Symptoms of alcohol dependence and recurrent use of alcohol were observed primarily in the presentations with SI (Nock et al., 2008a). The assessments of a young male patient attempted to explore the underlying factors contributing to the recurrent alcohol use:

*'Today drinking heavily 10 cans of Stella...Began drinking alcohol socially aged 16 when went to pub with parents was allowed 2 halves of larger. Drinking heavily since aged about 20. Drinking excessively since death of mother. Normally drinks 10 cans of Stella and tops up with spirits. Drinks first thing in the morning if does not drink gets withdrawal symptoms'.* (SI 464.1)

#### **4.5. Themes from the Mental Pain Scale (OMMP; Orbach et al., 2003a)**

As discussed in chapter 2 (2.1.i) and chapter 3 (3.4.ii), the nine core principles of the OMMP (Orbach et al., 2003a) namely irreversibility, loss of control, narcissist wounds, emotional flooding, freezing, self-estrangement, confusion, distancing, and emptiness, and their sub-principles (see framework 1) were applied to all 61 assessments using thematic analysis. Similarities and differences between the presentations with SI and those with SH were found. Those will be presented below.

**Framework 1. Thematic Analysis using the Mental Pain Scale Factors (Orbach et al., 2003a)**

<b><i>Thematic Group</i></b>	<b><i>No of times a theme was coded in the presentations with Suicidal ideation</i></b>	<b><i>No of times a theme was coded in the presentations with Self-harm</i></b>
<b><i>Irreversibility</i></b>	9	11
I have lost something that I will never find again; The pain will never go away The difficult situation will never change; The world has changed forever My life has stopped; Something in my life was damaged forever; I can't change what is happening to me; I can't change what is happening to me.		
<b><i>Loss of control</i></b>	5	8
I am afraid of the future; I have no control over the situation; There is uncertainty about my life and myself; I have no idea what to expect of the future I have no control over my life; I am completely helpless; I have no control over what is happening inside me; I am completely defeated; I will fall apart; I cannot trust myself		
<b><i>Narcissistic wound</i></b>	7	13
I am rejected by everybody; I feel abandoned and lonely; Nobody is interested in me; Others hate me; I am worthless		
<b><i>Flooded</i></b>	6	6
My feelings change all the time; There are strong ups and downs in my feelings I feel an emotional turmoil inside me; I am flooded by many feelings		
<b><i>Freezing</i></b>	2	1
I feel numb and not alive; I feel paralyzed; I cannot do anything at all		
<b><i>Self-estrangement</i></b>	3	4
I feel that I am not my old self anymore; I feel as if I am not real; I am a stranger to myself		
<b><i>Confusion</i></b>	7	10
I cannot concentrate; I have difficulties in thinking; I feel confused		
<b><i>Distancing/</i></b> <b><i>[Support Asked]</i></b>	8/ [12]	8/ [15]
I want to be left alone; I need the support of other people; I don't feel like talking to other people; I can't stay alone		
<b><i>Emptiness</i></b>	10	5
I can't find meaning in my life; I have no desires; I have no future goals		

(R) = Scored in reverse.

## **Irreversibility**

This theme was pertinent in nearly one third of the SI (nine) and SH (eleven) assessments. Patients discussed during the assessments about stressful life events that have caused their lives, in their minds, to be irrevocably different. There was both a sense of loss that was irreversible and emotional pain as a result of that loss. Those life events were primarily related to loss of partner either through death or separation, loss of family members either through family breakdown or death, loss of job, loss of fertility. Furthermore, a patient was experiencing a dramatic change in his general functioning and emotional state following a traumatic brain injury as a result of a car accident. A male patient who presented in A&E with SI on five occasions experienced a number of losses. The clinician who undertook the psychosocial assessment on one of those occasions noted:

*'He thought that everything was wrong and that his life had now 'finished'. His girlfriend has been in Scotland; she had given birth; however, he had no contact with the baby'. (SI 228.3)*

The intensity of painful feelings experienced did not seem to differ between those who had actually lost a partner/ family member (through death) and those who had separated from partners or were experiencing difficulties in family relationships. All of those losses and the pain associated with those felt to be intolerable.

The assessment of a patient who presented with SH referred to the multiple losses:

*'He describes ruminations over his losses and the state of his life which go over and over in his head all day, from waking. This makes him feel miserable and he concludes from his ruminations only that he has no way out of humiliation and failure than death'. (SH 84.2)*

The assessment of the latter patient was giving a sense that he was perhaps through the SH act attempting to escape from the humiliated self he was experiencing.

## **Loss of control**

This theme emerged in only five SI assessments and eight SH assessments and referred to patients' sense of profound helplessness in changing their lives; those feelings of helplessness were found to be associated with the breakdown of

marriage/ relationships, environmental stressors, and finally, mental health illness. In the SI cluster this theme was primarily found in assessments of female patients. All four female patients whose assessments' referred to loss of control faced marked difficulties in relating to others, either in their personal or professional life which they associated with their suicidality. The only male patient with SI to whom this theme was pertinent presented in A&E expressing despair that he had lost control over himself and his life. He was subsequently filled with suicidal thoughts towards himself and homicidal thoughts towards his wife.

*'Apparently patient got into a state of agitation, lost control saying to his wife that he could do something dangerous so he asked her to lock him into a cupboard'. (SI 255.0)*

The assessment conveyed the patient's intense anguish for having lost control over his inner self, and his worry that there was no escape from what he was experiencing. Interestingly, the nature of the relationship between the couple was not discussed in the assessment.

One of the patients with SH for whom the theme of loss of control was pertinent, felt that he had no control over his situation and life, and more specifically his wife's decision to separate from him. The loss of control and the abandonment seemed to have caused him to feel completely defeated and angry for not been able to exercise some control over the situation.

*'...a strong sense of hopelessness and helplessness. Seems preoccupied with his inability to control his fate and his immediate world'. (SH 84.0)*

In addition, two assessments explored patients' sense of having no control over their SH or themselves:

*'She admitted that every time when she had this desire of self-harm she could not control herself and she was not even fully aware of her action nor wanted to resist the self-harm...Most of the times she did not remember exactly why she decided and did the self-harm or what really happened at that moment'. (SH 59.2)*

### **Narcissistic wound**

Differences emerged in the prevalence of this theme as it was found most often in SH assessments (13) compared to SI assessments (7). Feelings of abandonment by partners or family members/friends were noted in the vast majority of these

assessments. For one of those patients presenting with SI, the separation felt like an intolerable catastrophic event, which caused him to be filled with anger. The clinician noted:

*'He said he was feeling suicidal on account of his wife wanting to divorce him and was not prepared to accept her decision. (patient's name) appeared to be very entrenched in the loss of his marriage...He mostly came across as being angry'. (SI 84.0)*

A female patient with a diagnosis of learning disability (LD) who presented on four occasions repeatedly reported experiences of feeling abandoned by her boyfriend and her friend. One of those assessments concluded:

*'Claims she cut herself because she was feeling low and that her friend had not visited her...(patient's name) has a significant history of deliberate self harm and appears to cut when she feels let down'. (SH 24.5)*

The assessments of this patient gave the impression that she was totally unable to tolerate any separation; she felt panicked, abandoned and raged which she perhaps unleashed through the SH episodes.

A male patient, presenting with SI, was deeply troubled by feelings of rejection by his family. While that patient had recently separated from his partner, feelings of abandonment or rejection were not noted in regards to that. His assessment noted:

*'Family have rejected him and he claims want nothing to do with him... states family don't want to know him'. (SI 464.0)*

Throughout this patient's assessment, it was felt that he was not able to manage his life independently and that he had an intense emotional need for a parental figure; his Mother had died and his Father had abandoned him, which he could not tolerate. He was filled with anxieties, anger and feelings of isolation; his life was described to be in a total state of chaos.

A male patient, presenting with an overdose, reported feeling insulted and rejected by his wife and her family who doubted his masculinity. That assessment conveyed a strong sense of the patient feeling humiliation and disgrace.

*'...despite his frequent attempts to approach her, his wife consistently refrained to have an intercourse; but later blamed him for not being a real man because he would not usually insist on the issue. He also said that they had separated their bedrooms since 2 weeks ago...(patient's name) had told his GP, especially as he was feeling*

*awkward & insulted by his wife's comments & wanted some scans to be done to ensure his masculinity & potency'. (SH 37.0)*

Finally, two SI assessments and two SH assessments of female patients made reference to patients feeling a profound sense of worthlessness; three of those patients suffered from depression. All of them were faced with a loss/ trauma; however, of a different nature (being rejected by manager, worries about partner's fidelity, a history of sexual abuse and as a result feeling unworthy and feeling a neither a good enough mother nor a good enough employee).

### **Flooded & Freezing**

Interestingly, the theme of 'being flooded' was not very often found in the assessments of patients presenting with SI (6) and SH (6). Two SI and one SH assessments discussed significant changes in the patients' feelings with their mood oscillating between 'up and down'. The patient presenting with SH had recently relocated to the UK and had been trying to adjust in various ways (for example, climate, studies, accommodation). He described his mood as fluctuating between too high and too low.

*'On further questioning, says that he has had episodes of 'high' as well as 'low' '. (SH 454.0)*

Four patients with SI and five patients with SH described a sense of feeling flooded by worries and negative feelings around relationships; one in particular described a sense of her *'body filling up to the point where it might explode'* (SI 458.0). This patient was in an emotionally overwhelming state further to difficulties in her relationship with her manager and episodes of being bullied at work as well as a sense of being ashamed/intimidated in the army. Similarly, a female patient who was faced with the death of her parents and a divorce from her husband appeared to be in an emotional turmoil; her assessment noted:

*'can't cope with all the things that I have to deal with all getting too much. Just want to stop the world and get off'. (SI 496.0)*

A male patient presenting with SH felt abandoned by his family, partner and friends, as well as faced difficulties with finances and with finding a job. As a result,

he appeared to be flooded and overwhelmed by different feelings which he could not distinguish or perhaps separate in his mind:

*'he feels so overwhelmed by emotions (anger, sadness, etc he cannot differentiate)'. (SH 464.0)*

The theme of freezing was only applicable to two SI assessments in which a male and a female patient talked about being unable to do anything at all. Both were patients who presented repeatedly in A&E with suicidality, had thoughts of harming others and were making concerted efforts to ask support from services around them, by highlighting their sense of feeling paralysed. A female patient presenting with SH reported an experience of freezing by indicating being totally paralysed and unable to do anything in the face of financial difficulties stemming from problems with claiming benefits.

### **Self-estrangement**

This theme was found in a small number of assessments in both clusters of presentations. The three patients with SI described a sense of not being their old self further to changes in their lives (traumatic brain injury, being an asylum seeker, developing psychosis). Four SH assessments identified issues of self-estrangement with dissociative states being indicated in three assessments. The assessment of a young male patient noted:

*'Not certain what happen tonight. States that he suddenly found himself drinking a mouthful of white spirits from the bottle. Not planned or pre-mediated immediately regretted and spat it out, before pouring away the rest of the bottle with him. Had stomach pain, so called LAS to hospital bringing empty bottle with him'. (SH 454.0)*

Another SH assessment for a male patient with a sudden and recent deterioration in his functioning reported to feel disconnected from his previous life and people around him:

*'Self-isolating, describes living in my own little bubble'. (SH 345.0)*

The assessment of the aforementioned patient described him as somebody who was functioning in an automated way, for example working, watching TV, sleeping as if there were no feelings of enjoyment or satisfaction, disconnected from himself and the world around him. That patient's previous life involved painful experience of



being repeatedly abused by his parents which might have been related to his estranged and isolated self.

## **Confusion**

The theme of confusion was noted in seven SI assessments and ten SH assessments. For patients with SI, confusion was found to be associated with hallucinations and pseudo hallucinations, paranoid states, and difficulties in concentration. Difficulties in concentrating stem from patients being profoundly preoccupied with work-related stressors nearly to the point of ruminating, which was causing their minds to have no space for any other thoughts. In addition, a patient presenting with SI and intoxication, reported that his:

*'head had become messed up' and 'he could not tell what was true and what was not'. (SI 23.1)*

That patient had been experiencing difficulties in his relationship with another resident in the hostel where he was residing. A remark had been made, which had caused him to be terribly confused and upset. At various points during his assessment, there was a sense that he felt that he was losing his mind and that his self was becoming disintegrated.

In the SH cluster, the theme of confusion was associated with impairments in the cognitive functioning, concentration difficulties related to traumatic and muddled thoughts. One of the patients with impairments in cognitive functioning (diagnosed with LD), who presented on four occasions, was noted to have difficulties with concentration. That might have resulted partly because of her cognitive impairment but also partly due to painful experiences of abandonment and rage/ frustration she was feeling. Patients who were preoccupied by previous traumatic events (sexual abuse and abandonment by wife) were unable to concentrate and think of anything else apart from their painful and unresolved experiences. The assessment of a patient with a personality disorder and a history of emotional abuse noted a general muddle in the thoughts he was having:

*'Feels thoughts become jumbled at times, though also has periods when he is able to think more clearly and 'rationally'. (SH 345.0)*

Whilst the aforementioned patient appeared to have been relapsing, it may well be that other factors had contributed to this sense of losing one's mind.

## **Emptiness**

This theme was most commonly found in the presentations of SI (10) compared to SH (5). The theme of emptiness was related to a wide variety of difficulties including separation from and difficulties with partners, work related stressors, financial stressors, physical pain, and distress related to hallucinations and delusions. The assessment of a male patient presenting with SI who had recently separated from his partner clearly associated his suicidality with the loss of the relationships. He felt that he had nothing to live for. The assessment noted:

*'his wife's perusing divorcee proceeding and when looking at potential protective factors that would stop him from acting out he said that his parents were old and that they were going to die anyway and that he had nothing else to live for'. (SI 84.0)*

Some of the assessments conveyed a more intense loss of meaning, and lack of future- directedness. The assessment of a patient presenting with SH indicated:

*'-No enjoyment  
-Says she looks forward to nothing  
-Feels there is no point in going on  
-No future I have no plans for the future 'My future is shit'  
-No hope  
-No future'. (SH 267.0)*

A male patient presenting with SH had been suddenly faced with financial difficulties and unemployment both of which he considered as unsolvable. He had no supportive network around him. Those predicaments were reportedly related with experiences of having no meaning or direction in his life.

*'He said the tunnel looks black and he does not see any need to carry on. He reported lack of motivation, suicidal ideation and that he does not have any reason to carry on'. (SH 127.0)*

## **Distancing**

Five SI and eight SH assessments noted that the patients did not wish to be seen and discuss their presenting difficulties with the A&E clinicians. One clinician described:

*'She stood up, walked straight past me and through the front door of A&E stating I am not waiting, I want to go home. Despite attempts I could not persuade her to stay' (SH 403.0).*

Two assessments of a male patient presenting with SH described him as a patient who did not 'cooperate' with their assessment. That patient seemed to prefer to be seen by his own psychiatrist and community team with whom he felt he had a good relationship. Three patients with SI and three patients with SH (out of those that did not wish to be seen in A&E) referred to their tendency to isolate themselves and to not seek contact with friends/ family.

Furthermore, two patients presenting with SI appeared to have been asking for support; nevertheless, they did not accept the treatment modality/ service offered and therefore, preferred to not receive any support. Different narratives were offered about this including transitions to the UK and being depressed. Finally, one patient presenting with SI was a refugee whose command of English was limited and therefore, could not communicate with his flatmates in the hostel placed.

*'Finds it difficult to live there as finds himself unable to communicate with other people because of the language barrier. Finds himself quite lonely... socially isolated refugee'. (SI 328.0)*

Contrary, the patients' need to talk to other people and to seek support was highlighted in twelve SI and fifteen SH assessments. All of the SI assessments and twelve SH assessment underlined the patients' need and wish to receive support from mental health services. For instance, one clinician wrote:

*'...Thinks that having some time and space to think along with someone to talk to would be helpful'. (SI 223.0)*

Two out of the twelve patients with SI made reference to a supportive family and/or friends and their strong wish to relate to them. A patient with SH appeared to be very isolated from her family despite her wish to have contact with them; she associated her death wishes with her loneliness. Similarly, two assessments involved a female patient who was described as unable to be left alone and seemed to have a very limited ability to contain herself. Her SH episodes correlated with feelings of loneliness.

#### **4.6. Summary**

This chapter explored the characteristics of patients presenting in an A&E department further to an episode of SI or SH. Patients' stories recorded in the psychosocial assessments were explored with the use of thematic analysis, which was described in chapter 3. The following conceptual categories emerged: ill health, environmental stressors, relating to others, and significant childhood experiences and adulthood experiences. Both groups of patients were similar in terms of age, gender, marital status, employment status, previous psychiatric treatment, previous SH episodes, and time of presentation. The group attending A&E with SI, however, was more often residing in their own houses/flats than the group presenting with SH. Patients presenting with SH were more likely than those presenting with SI to arrive at the A&E with the LAS. With regards to the SH presentations, self-poisoning was the most commonly used method of SH.

Despite differences the model of psychosocial assessment was very similar for both sets of presentations and the themes recorded in both groups of presentations were very similar. The assessments showed that most patients were not in a relationship. Nevertheless for those patients who were in a relationship, disrupted relationships with partners or spouses were found to be the most frequent life stressor in both groups (Haw and Hawton, 2008; Liu and Miller, 2014). Jobes (2000) argues that many suicidal states are defined and connected to either the existence or the absence of certain key relationships. Distress and feelings of abandonment by partners and on some occasions family possibly associated with rage were conveyed in the assessments. These experiences may have caused patients to experience negative changes within their selves- a sense of feeling damaged, incomplete and impoverished (Orbach, 2011). Allen (2011) suggests that the suicidal patient's aloneness can be understood as the absence of an emotional connection with a mentalising other. Motz (2009a) approaches SH as a sign of hope in that it is an antisocial act, which seeks a psychosocial response from people around the patient.

A limited number of psychosocial assessments involved either partners or family members exploring the relationship between patients and families/partners. Acts of SH while directed against the self, have indirect recipients, such as partners

or parents who may become distressed and feel guilt for failing to protect the patient from the SH act (Motz, 2009b). The impact of the patient's difficulties on spouses was noted in a very few assessments. Very few patients were in paid employment in both groups (Coope et al., 2014; Newman and Bland, 2007). Stressors related to accommodation and finances were similarly reported in both groups.

Both of the groups appeared to have similar experiences of losses in childhood and adulthood. Experiences that could lead to trauma were often shared, for instance being raped by a fellow student; nevertheless, the meaning to the patient and the way that event had been processed were not always explored in the assessments. Therefore, it was occasionally difficult to make inferences about the impact of an event to a patient and its potential relationship with the presentation. A small number of assessments in both groups revealed multiple losses for some patients. Similarly on some occasions those were presented as an array of stressors (often in lists) rather than a discourse about the way each of those factors and collectively were affecting the patient. Abuse and trauma have been found to be associated with SH and suicidal states (Fliege et al., 2009; Lang et al., 2011; Miller et al., 2013.) The function of SH for people who have been abused can be releasing tension and anxiety, and may also reveal the creation of a split self – the part of the self that can act as a perpetrator towards the helpless, victim aspect (Motz, 2010). Some assessments described the patients' distressing memories and preoccupation with past trauma. Hale (2008) suggest that acting out is the substitute for remembering the trauma and unconsciously aims to reverse it and to master currently the early experiences suffered passively.

Both groups of presentations were nearly equivalent in terms of presence of mental illness. Ashead (2010) suggests that an understanding of SH should take place in conjunction with a psychiatric assessment. Affective disorders were found to be the most common mental illness both in presentations with SI and those with SH. Although alcohol related disorders were more frequently found in the patients presenting with SI (Nock et al., 2008a), personality disorders were more common in the presentations with a SH episode (Hawton et al., 2013b).

Finally, the themes of the OMMP (Orbach et al., 2003) were found to be pertinent both in the assessments of SH and SI presentations. The main noticeable

differences observed between the two groups were in the themes of emptiness and narcissistic wound. In relation to emptiness, those were more prevalent in the assessments of patients presenting with SI than SH. Experiencing a sense of woundedness or a sense of catastrophic abandonment was more common in the presentations with episodes of SH. The theme of wishing support was the most prevalent theme in both sets of presentations. Some assessments gave a better sense than others of the unbearable pain the patients were experiencing that related to experiences of loss/ abandonment and emptiness primarily but also a sense of disintegration experienced by some patients (Maltzberger, 2004). Shneidman (1993) associates suicidal states with unbearable mental pain, which becomes an amalgamation of guilt, humiliation, loneliness, loss and dread (Orbach, 2011). It was thought that similarly to the discourses about the impact of bio-psychosocial stressors on the patients, the narratives about the patients' experiences of mental pain were somewhat limited on occasions. However, the potential emotional impact on the clinicians assessing those patients in unbearable pain should be acknowledged.

In conclusion, striking similarities emerged in the two clusters of presentations. Overlapping genetic and environmental influences on SH and SI have been reported (Maciejewski et al., 2014). Whilst it is acknowledged that psychosocial assessments are constructed by the way clinicians make sense and interpret patients' accounts during the assessment, clinicians were found to make some attempts to relate to patients' emotional world and distress as well as to the social adversities faced. The following chapter will present the findings of the psychosocial assessments with regards to making sense of SH and SI, conceptualising risks and offering an aftercare plan.

## **Chapter 5- Findings from Psychosocial Assessments: make sense of the presenting difficulty, assessing risks & aftercare planning.**

### **5. Introduction**

As outlined in chapter 4, this chapter presents the themes generated from the psychosocial assessments in relation to how clinicians and patients understood the presentations (meaning of SH and SI), how clinicians approached and assessed risks and what treatments/ interventions offered at the end of the psychosocial assessment. Similarly to the previous chapter, the themes identified in the analysis are grouped within three wider conceptual categories namely, making sense of the presentations, risk assessments and aftercare plans. These conceptual categories comprise thematic groups and thematic categories. Considering the similarities that emerged between the presentations with SI and SH, the results are presented under the previously mentioned conceptual categories: making sense of the presentations, risk assessments, and aftercare planning. Furthermore, differences and similarities with regards to how nurses and doctors assessed and managed SH and SI will be discussed.

Excerpts from the data will be presented and will appear in quotation marks following by their origin as illustrative examples of the analysis.

#### **5.1.Making Sense of the Presentations**

The model that emerged from the data analysis using NVivo (QSR, 2010) consisted of four levels of categories developed during the coding. 'Making sense of presentations' is a conceptual category (level 1) consisting of two thematic groups of categories namely, 'patients' meaning' and 'clinicians' formulations' (level 2). The third level consists of two categories namely, 'presentations with SI' and 'presentations with SH' which have subcategories (see Appendix C.4).

### **i) Clinicians' Ascription of Patients' Meaning of their Presentation**

Clinicians' recorded the meaning patients assigned to their suicidal thinking in approximately one third of the SI assessments (9). Patients associated their suicidal thinking with the following: hopelessness, releasing tension from overwhelming feelings, and mental illness (psychosis). The assessment of one of the patients who associated her SI to her need to obtain relief from overwhelming worries and painful feelings stated:

*'reports that she has been feeling very stressed for several weeks. Intense worries about her husband's drinking. Denies that he drinks daily, but worries about him when he goes out for a drink with his friends, as does not tend to eat during the day and alcohol 'goes straight to his head'. Also very worried about her youngest granddaughter who was born 2-3 weeks ago, with a hole in her heart and is currently inpatient at ... reports that she has had thoughts of cutting herself for 2 weeks. Denies any suicidal intent saying that she did not want to die, but thought that cutting herself would make her feel better'. (SI 380.0)*

The assessment of a male patient who was an asylum seeker referred to the numerous stressors the patient was experiencing and which he associated his suicidal thinking with.

*'Currently living in shared accommodation arranged by home office for refugees. Finds it difficult to live there as finds himself unable to communicate with other people because of the language barrier...His (suicidal) thoughts were about his refugee status, unhappiness with current accommodation and financial support, not able to find an employment and that he is not getting the physiotherapy treatment that he wants. He felt that things were not getting better for him.'* (SI 328.0)

For SH episodes, the majority of the assessments (21) discussed the meaning patients assigned. Hopelessness, mental illness (symptoms of psychosis and alcohol abuse) and releasing tension/overwhelming emotional states were the most commonly factors associated with SH. It is not possible to ascertain whether the concept of 'hopelessness' was expressed by the patients or whether it was the clinicians' interpretation of the patients' narratives. One of the patients who was experiencing hopelessness thought that his despondency was caused by his recent loss of employment and financial problems.

*'Mr A informed me that his problem started about 8 weeks ago when his cab broke down and he has been unable to fix it due to financial difficulties. Since then he has not worked. About 6 weeks ago he started feeling really low and suicidal because of that'. (SH 127.0)*



Patients who understood their SH episode as an attempt to get relief from unbearable feelings were mostly experiencing difficulties in their relationships with their partners, and felt abandoned and rejected. A young male patient was experiencing a psychotic episode, which caused him profoundly excruciating worries and anxieties. The clinician wrote

*‘started having visual hallucinations, he sees lines and patterns of his person – panic attack – palpitations – starts to worry. Ruminates on a number of things: fear of blood, the devil, black magic. Increasing anxiety and starts to feel as if he is controlled by a force...Very distressed by the above. Unsure how to get relief...Mr X ... (patient’s name) reports that he was feeling in a bad way and could not deal with the increased worries. Hence, he harmed himself.’* (SH 351.0)

Precarious housing situations were linked to an overdose by a male patient who attended with a single SH episode. Finally, only one female patient, who presented once, thought that her SH episode had been caused by a clear wish to die.

## **ii) Clinicians’ Formulations**

A summary of clinicians’ ways of making sense of the presentations is presented in table 1. In relation to the presentations with SI, clinicians discussed their own interpretation of the patient’s suicidal thinking in nineteen out of the twenty-nine psychosocial assessments. *More than one way of understanding an episode of SI was recorded in some assessments.* The most common ways of understanding suicidal thinking was as a state related to mental illness (personality disorder, depression, psychosis), alcohol intoxication, and to be triggered by difficulties in interpersonal relatedness. A clinician who thought that the patient’s suicidality was associated with a depressive episode indicated in her formulation the precipitants of the depression. She noted:

*‘25 years old single army dental nurse of Jamaican origin, living in army barracks self-presented to A&E with depressive symptoms associated with active suicidal ideation secondary to extreme work stress brought on by severe bullying, shunning down and recent demotion ...Moderate depressive episode precipitated by stressful situation at work, mainly bullying, intimidation.’* (SI 17.01)

Interestingly, although the assessment of a male patient identified a number of losses in the patient’s life, the clinician merely concluded that the patient experienced

SI in the context of alcohol intoxication and did not integrate in her formulation the multiple stressful life events the patient was facing.

*‘Reports has always had low mood. Since death of his Mother four years ago family have rejected him and he claims want nothing to do with him. Following death of mother drinking and use of cocaine have escalated as has offending behaviour, mainly crimes of acquisition. Girlfriend of four years and mother of his 3 year old son ended relationship just before Christmas. Today drinking heavily 10 cans of Stella and told friend in hostel that he felt like killing himself, friend called an ambulance...27 year old white british man with primary problem of alcohol and substance misuse, who has thoughts of self-harm whilst intoxicated.’ (SI 464.0)*

Social/ environmental factors (unemployment, financial problems, and accommodation) were considered to account to some extent for the suicidality experienced by patients. Four assessments showed that the patients were experiencing multiple stressful life events and/or losses, which were thought to collectively contribute to the patients’ SI. One of those assessments noted *‘long standing unresolved loss issues’* (SI 21.0) referring to the loss of parents, former spousal violence and separation from her husband.

With regards to similarities and differences between professional disciplines, nurses were more likely than doctors to indicate their own understanding of the patient’s SI explicitly. Doctors were more likely than nurses to relate SI to a defined psychiatric illness. It might though be that doctors assessed those patients who presented symptoms of mental illness at the point of initial presentation or had a history of mental illness.

**Table 1. Making sense of presentations: clinicians’ formulations**

	No of times a theme was coded in the assessments of Suicidal Ideation	No of times a theme was coded in the assessments of Self-harm
Alcohol use	5	2
Environmental stressors	3	3
Interpersonal Relatedness	5	5
Mental Illness	7	11
Seeking help	2	1
Unbearable feelings	3	7
Dissociation	0	1
Impulsivity	0	1

With regards to the interpretations of SH episodes, clinicians recorded their own understanding in twenty-one out of the thirty-two psychosocial assessments.

*More than one way of understanding an episode of SH was recorded in some assessments. SH was most commonly associated with the following: mental illness, coping with overwhelming and unbearable feelings, ruptures in interpersonal relationships and social adversities (financial and housing difficulties). The following psychiatric disorders were thought to relate to the SH episode: personality disorder, psychosis, depressive disorders, anxiety disorder and possibly organic psychosis related to physical health problems. The assessment of a 71-year-old lady noted:*

*'...Reports gone down to river Thames to wash her hands. Then fell in (denies jumping). Denies intent to harm herself... Consequently admitted that events leading to admission to were a genuine suicide attempt... Deliberate attempt act of self harm and from cousin's account, diagnosis in behaviour coincides with thyroid operation resulting in ?organic psychosis/affective component.'*(SH 148.0)

As for the comparison between disciplines, doctors and nurses were equally likely to offer a discourse about their own understanding and interpretation of SH. Similarly to the assessments following an episode of SI, while doctors were more likely to understand the meaning of SH as related to a psychiatric illness, assessments undertaken by nurses offered a wider variety of explanations and interpretations regarding the underlying reasons for SH.

## **5.2. Risk Assessments**

The majority of the psychosocial assessments (48) included formulations about risks. The model that emerged from the data consisted of four levels of categories. Risk assessments is a conceptual category (level 1) that is made up of four thematic groups of categories namely, risk matrix, identified risks, risk factors and protective factors (level 2). The third level comprises individual categories within the four thematic groups (level 3). Finally, some categories themselves can be described in terms of subcategories (table 2 summarises the emerging model). The results are presented under the previously mentioned four thematic groups of categories. Furthermore, risk assessments undertaken by nurses and psychiatrists are compared in terms of the overall content.

**Table 2. Conceptual Category - Risk Assessments (Level 1)**

<b>Level 2- Thematic Groups</b>	<b>Level 3- Thematic Categories</b>	<b>Level 4- Subcategories</b>
<b>Identified Risks</b>	Risk to children	No risk to children Risks to children
	Risk to others	Aggression No risks identified
	Risks to self	Assault Exploitation Health risks Self-harm Suicide- Death
<b>Protective Factors</b>	Access support No current SH thoughts Family & friends Hopeful about future Mental Health No history of self-harm No intent No protective factors No use of alcohol-drugs Other protective factors	
<b>Risk Factors</b>	Alcohol & Drugs Communication difficulties Current suicidal thoughts Helplessness History of self-harm Hopelessness Impulsivity Insight Intent Mental illness Other risk factors Psychiatric Services Housing/Unemployment Stressful life events	
<b>Risk Matrix</b>	Overall Risk Rating	High Low Moderate
	Timeline	Chronic Risks Immediate Risks

Twenty-four psychosocial assessments following SI and twenty-four psychosocial assessments following SH included some form of risk assessment. On one occasion the patient with SI had left before the assessment was completed; hence, a risk evaluation was not undertaken. Three assessments, of a patient with SH who attended recurrently, were not completed as the patient had left before seen. Four assessments involved patients with SH who were already admitted to the CDU.

### **i) Risk Matrix & Identified Risks**

Twelve SI assessments and eighteen SH assessments pointed out the overall level of risk. These assessments referred to different risks namely risk for SH, risk for completed suicide, risk towards others and property. Overall, around a quarter of SI risk assessments and a quarter of SH risk assessments estimated that the risk of SH or suicide was high. A clinician stated:

*'There is a high chance of ..... (name of patient) being successful in ending his life'.* (SI 84.1)

Some assessments identified potential risks without indicating the level of risk. Risk of exploitation was identified in three assessments of a learning disabled patient who presented with repeated episodes of SH. Risks of skin infection and cutting blood vessels were identified in two out of her four assessments. Interestingly similar risk factors were not identified in other patients presenting with lacerations which may relate to the clinician being aware of that patient's cognitive difficulties and possible associated difficulties with self-care skills/ activities of daily living.

With regards to risk to others, seventeen SI and four SH assessments made reference to possible risks. Those were generally related to risks to others or specifically risks to current or former partners. The assessment of a male patient with SI noted:

*'Risks...To others: fleeting thoughts to take her former partner with her if he is not interested in having a relationship with her but has realised that this is not appropriate and has no formed plans'.* (SI 223.0)

The assessment of a young female patient with SH who had been sexually abused during her childhood pointed out that the patient had

*'made some self-accusations of being sexually abused woman turned abuser. This needs further exploration in time' (SH 20.0)*

As for the specific risks to children, those were identified in one SI assessment and four SH risk assessments. The clinician conducting an assessment with a young male with SI and long standing alcohol use appeared seriously troubled about the wellbeing of the three year old son of the patient with whom the patient had regular contact. The patient shared during the psychosocial assessment that he had been smacking his son. He shared his wish to have overnight contact with his son in the hostel where he was residing. The clinician cited her worries about both the physical chastisement and the likelihood of the child sleeping in a hostel where former offenders were residing.

*'Son (name) aged 3. (patient's name) reports he has no thoughts of harming (son's name). Has disclosed that he often smacked (son's name) quite hard when he is naughty. States he has never caused bruising but often leaves a red marks. (patient's name) also informed me that (son's name) mother brings child to visit him at the hostel. He would like her to allow (son's name) to stay overnight but she won't allow it.*

*I would be concerned that this would not be an appropriate environment for a young child.*

*The smacking of (son's name) is also concerning in view of (patient's name)'s self-reported anger management problems'. (SI 464.0)*

There was though a sense that the clinician was preoccupied by those worries and addressing those worries/risks appeared to be central in the care planning perhaps at the expense of the needs of the patient.

Another patient shared her own worries about the impact of her mental illness and alcohol dependence on her sixteen year old son. She added that her son would often remain at home and not attend school in order to take care of his mother. The clinician appeared to share the patient's worries about the emotional wellbeing of her son and noted *'emotional and possible physical neglect'* (SI 15.0). The assessment concluded that the sixteen year old boy was looked after by his father and extended family members. Hence, the risks to the patient's son were eliminated in light of the protective factors.

A female patient shared her worries and guilt about the impact of her SH episode and her mental illness on her children. The clinician wrote

*‘She stated her actions make her a selfish, cruel and bad mother. She was relieved her children did not have the idea of a dead mother to contend with. Just a mentally unwell mother who had abandoned them and tried to kill herself’. (SH 21.0)*

That patient was a social worker whose children had been referred to children’s social care.

Furthermore, a patient who had recently given birth prematurely and presented with an overdose was thought to have difficulty in making sense and responding to the needs of her baby, in the context of her being preoccupied with her childhood experience of sexual abuse. The clinician felt that he could not make a judgement about the possibility of this mother rejecting the baby or absconding with the baby from the A&E department. He noted that the patient was caring for the baby appropriately in the presence of her partner. Finally, a male patient presenting with an overdose had reportedly sent a text message with a sexual content to the daughter of his landlord who was thirteen years of age. That incident had led to the Police being involved.

## **ii) Risk Factors**

The most commonly reported risk factor in the SI cluster was presence of suicidal thought, which was recorded in approximately one third of the assessments (table 3 summarises the risk factors identified). For example, a risk assessment identified *‘intrusive thoughts to end her life’* (SI 312.0) as the primary risk factor. Whilst all patients in the SI cluster presented with SI, SI was identified as a risk factor in nine assessments. This could be interpreted in various ways. Further to the assessment, clinicians may have concluded that the risk for further SI was not significant or in the process of the assessment, SI may have diminished. This could be attributed to different factors such as the link some clinicians made between SI and alcohol use or the therapeutic quality of the psychosocial assessment.

History of SH and current mental illness were found to be the most common risk factor in the SH cluster as it was highlighted in one third of the risk assessments (table 3 outlines the risk factors identified). The assessment of a young psychotic male patient who had jumped out of a window noted *‘mental state has deteriorated resulting in severe distress and Self harm’*. (SH 351.0)

**Table 3. Presentations with SI & SH: Risk factors for SH and/or suicide**

Risk Factors	No of times a theme was coded in the total sample	No times a theme was coded in the Assessments of Suicidal Ideation	No of times a theme was coded in the Assessments of Self-harm
Current mental illness	16	6	10
History of self-harm	14	6	8
Current suicidal thoughts	13	9	4
Intent	3	1	2
Hopelessness	4	3	1
Impulsivity	9	5	4
Stressful Life Events	8	5	3
Alcohol and drug	7	6	1
Isolation	7	3	4
Housing	6	4	2
Unemployment	6	3	3
Lack of engagement with services	2	-	2
Other	6	2	4

Although some patients had previous inpatient admissions for SH or psychiatric disorders, history of inpatient treatment was not cited as a risk factor in any of the assessments. None of the assessments distinguished between risk factors for SH and completed suicide. Interestingly, although some patients had a history of SH, this was not mentioned as a risk factor in the risk assessment.

### **iii) Protective Factors**

Clinicians occasionally attempted to elicit strengths in the patients and protective factors in the family/social system around them. Twelve SI and ten SH psychosocial assessments considered possible protective factors and thought of them in conjunction with risk factors. The most commonly cited protective factors included the thought of children, family members or friends, absence of mental illness and no current thoughts of SH.

The assessment of a female patient presenting with SI commented:

*‘...her 19 year old son appears to be her main protective factor...*

*Protective factors include her family but mostly and her son...*

*She said that she would be safe at home and currently the main protective factor appears to be her son and other children.’ (SH 312.0)*



Other protective factors less commonly referred to were willingness to access mental health services, no use of alcohol, lack of suicidal intent, normal cognitive functioning (SI cluster only), being insightful and being hopeful, notifying someone about the SH episode (SH cluster) and glad to be alive (SH cluster). No protective factors could be identified in one SI psychosocial assessment; the clinician noted

*'T appeared to be very entrenched in the loss of his marriage and when looking at potential protective factors that would stop him from acting out he said that his parents were old and that they were going to die anyway and that he had nothing else to live for...Attempted to explore protective factors which he was not willing to explore'. (SI 2.0)*

Similarly, the assessment of a female patient who presented with a single SH episode noted that the patient could not think of any of protective factors. She experienced profound hopelessness and considered her difficulties to be insoluble.

#### **iv) Clinical Styles: similarities & differences between disciplines**

Eight psychosocial assessments following SI were carried out by doctors<sup>5</sup>; six out of the eight assessments included a risk assessment. With reference to the content of the assessments, doctors offered a discourse about the identified risk factors for SH and/or suicide. Only three assessments estimated the level of risk. Two out of the six assessments identified high risk of SH/suicide. All six assessments considered risks to others and one identified protective factors. Risk assessments undertaken by doctors were brief.

Twenty-two assessments following SI were undertaken by nurses. Eighteen out of these assessments included a risk assessment. Six assessments estimated the level of risk. Three assessments pointed out high risk; it was unclear whether they were referring to SH or suicide. Eleven assessments carried out by nurses explored risks to others. Eight assessments undertaken by nurses included protective factors in their formulation of risk. Most assessments (12) carried out by nurses were detailed and attempted to note risk factors in all of the following areas: history of SH, mental illness, personal factors and social and environmental stressors. Nurses more often omitted to make conclusions about the risk of SH and/or suicide.

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<sup>5</sup> One patient was initially assessed by a nurse and subsequently seen by a doctor.

Twelve psychosocial assessments<sup>6</sup> after an episode of SH were carried out by doctors; eight out of those assessments included an evaluation of risk. As previously mentioned, the four assessments conducted by doctors with no risk evaluation were carried out in the CDU. All four assessments led to an admission. As for the nursing discipline, seventeen out of the twenty-one SH assessments conducted by nurses included a risk assessment.

SH assessments carried out by doctors were succinct, and often offered their view about the level of risk. Rarely did they integrate in their risk assessments precipitating and predisposing factors that emerged in the psychiatric, personal and social history assessment. Most SH assessments (11) carried out by nurses were detailed and attempted to evaluate risk factors in all of the following areas: history of SH, mental illness, personal factors and social and environmental stressors. Both disciplines identified similar risk factors namely, suicidal intent, previous SH, mental illness. Doctors were more likely to estimate the level of risk and to explicitly indicate risk of further SH and/ or suicide. On the other hand, nurses (7) were considerably more likely to comment on protective factors than psychiatrists (1). Similarly, nurses (8) identified risks to others more frequently than psychiatrists (3).

In summary, in both sets of presentations doctors were more likely than nurses to make a firm conclusion about the risks involved. Nurses were more detailed in their assessments but not always conclusive.

### **5.3. Aftercare Plans**

The vast majority of the psychosocial assessments following SI and all assessments of SH (55) included an aftercare plan. The themes that emerged from the data consisted of three levels of categories. Aftercare planning is a conceptual category (level 1) that is made up of five thematic groups of categories namely, mental health care, physical health care, welfare agencies, no service provision and patient's wishes (level 2). The third level comprises individual categories within the five thematic groups (table 4 summarises the emerging themes). The results for both

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<sup>6</sup> One patient was initially assessment by a nurse and subsequently assessment by a doctor.

clusters of presentations are presented under the previously mentioned five thematic groups. Furthermore, aftercare plans devised by nurses and psychiatrists are compared in terms of the overall content.

**Table 4. Conceptual Category -Aftercare Planning (Level 1)**

<b>Level 2-Thematic Groups</b>	<b>Level 3-Thematic Categories</b>	<b>No of times a theme was coded in the total sample (N=61)</b>
<b>Aftercare Plan-Patients' Views</b>	Agreement	10
	Disagreement	3
	Wish an admission	6
	Turning points	4
<b>Mental Health Care</b>	Admission Psychiatric Ward	12
	Drug & Alcohol Services	3
	Existing Treatment Plan	19
	Further Assessment	10
	Letter to the GP	9
	Psychopharmacology	6
	New Referral	5
	Return to A & E	9
	Transport	7
<b>Absence of Services</b>	No aftercare plan	7
	Provision of Information	9
<b>Physical Health</b>	Admission	2
	Liaison with Midwife/ Health Visitor	2
	Physical Health Checks	5
<b>Welfare Agencies</b>	Children's Social Care	3
	Liaison with Hostel	3
	Police	4

#### **i) Mental Health & Physical Health Care**

After the initial consultation and medical treatment, most patients in both clusters were discharged to outpatient treatment. Four SI presentations and eight SH attendances led to an admission in a psychiatric inpatient ward. Those admissions resulted from episodes of self-poisoning (3), self-cutting (2), jumping from height (1) and jumping into Thames (2). The most commonly found outcomes included

discharge to the services already involved (SI: 6; SH: 13), referral for further assessment (SI: 6; SH: 4), psychopharmacology (SI: 4; SH: 2), new referral to mental health services (SI: 2; SH: 3), advice to return to A&E (SI: 6; SH: 3), discharge to the care of the GP (SI: 4; SH: 5) and referral to Drug & Alcohol Services (3). Transport was offered on four occasions to patients presenting with SH and three to patients with SI.

Physical health checks were indicated in two aftercare plans following SI and three aftercare plans following SH. Liaison with the midwife was indicated in the aftercare plan of a patient with a very recent miscarriage who presented with SI. Similarly, liaison with a health visitor was indicated once because a patient presenting with an overdose, had a new born baby. Two admissions were decided due to the need for medical treatment following the SH episode. Patients who repeatedly presented were less likely to have an aftercare plan with specialist follow up.

## **ii) Welfare Agencies**

A referral to children's social care was made for the child of a patient presenting with a single episode of SI and intoxication and two patients presenting with SH. The patient presenting with SI was reportedly smacking his son. An admission to a mother-baby unit was required for one of the patients presenting with SH. As for the other patient with SH, although she appeared profoundly depressed, the precise rationale for the referral was not stated. It was unclear whether the last two patients had been informed about the referral. The police was contacted for a patient with SI and a patient with SH who had left before seen; hence, the Police was asked to perform a welfare check. A letter was written to the Police with regards to a patient who presented with SH and was being harassed by her neighbours. Advice was given to a patient who presented once with SH to contact the Police in order to identify ways of retrieving his belongings from his former accommodation. Finally, liaison with the hostel, where a patient was residing, was found in one aftercare plan for SI and two care plans for SH. The clinician involved contacted the hostel notifying the relevant staff of the A&E presentation. One of the aftercare plans noted:

*'I spoke to his hostel worker and advised them he has left hospital without being seen but if he wanted to speak to someone he could return. Hostel staff fully aware of mental health problems and deliberate self-harm history. No different concerns were raised by staff, they will speak to him on his return'. (SH 1.5)*

### **iii) Absence of Services**

Information about other services was provided in the aftercare planning process in six SI assessments and three SH assessments. Those included lists of GP Surgeries, local housing agencies and information about charities (Shelter for Christmas, Samaritans, Maytree, Gamblers Anonymous). Food and tea was offered on one occasion to a patient who repeatedly presented with SI. Four psychosocial assessments following an episode of SI did not lead to the division of an aftercare plan. Three psychosocial assessments were incomplete as the patients presenting with SI left before completion of the assessment.

### **iv) Patients' Views & Turning Points**

Turning points were found in four assessments. It was evident in one aftercare plan for SI and two aftercare plans for SH that the patients had refused the treatment offered; a referral to an outpatient service. With regards to patients' agreement with the aftercare plan, only four aftercare plans for SI and six aftercare plans following SH clearly recorded the patients' agreement. Patients presenting on four occasions with SI clearly expressed their wish to be admitted; nevertheless, only two presentations led to an admission. The clinician noted that a highly distressed and angry patient who was having homicidal thoughts appeared calmer at the end of the assessment and once the decision for an admission was announced to him:

*'When the plan of admission was explained to the patient, he dramatically changed in his presentation with being more cooperative, relaxed and pleasant'. (SI 7.0)*

Similarly, the assessment of a patient who had previously presented with SI and then with SH highlighted the patient's wish for an admission to a particular Hospital in order to *'sort everything out'* (SH 18.0). The aftercare plan of a female patient who had jumped into the Thames recorded the worries her husband had in relation to the aftercare plan and the decision to not admit her.

A turning point was noted in the assessment of a patient who presented with

SI following a miscarriage. She was deeply troubled by her partner's reaction who was blaming her for the miscarriage. The clinician undertaken the assessment noted a process by which the patient was able despite her own distress and profound sadness to make sense of her partner's experience and response:

*'She is quite distraught by this and so we explored this more fully and she acknowledged that this may be part of his way of coping / understanding the death of his first child, together'. (SI 4.0)*

A patient who attended following an attempt to hang himself was in despair regarding his separation with his partner. The separation was precipitated by the patient's gambling and loss of money. Whilst in the first stages of the assessment, the patient seemed to envisage that his life was not worth living without his partner, the clinician noted towards the end of her assessment that the patient started to coming to terms with the idea of separation. In addition, one SH assessment made reference to the change in the patient's presentation and attitude as the assessment progressed; although that patient was initially deeply agitated and refused to communicate by the end of the assessment he was much more communicative and grateful to the clinicians for their attempts to help.

#### **v) Clinical Styles: similarities & differences between disciplines for clinical management**

Differences and similarities between disciplines emerged with regards to the clinical management. Firstly, doctors were more likely than nurses to note the patient's agreement with the aftercare plan in both sets of presentations. Doctors were more likely than nurses to recommend an admission for patients considered at high risk or unclear risk compared to mental health nurses for both SI and SH. Despite the fact that a number of patients shared traumatic life experiences that were still troubling them, access to psychological and psychotherapy services was not often thought of. Nonetheless, doctors were more likely than nurses to discuss psychotherapeutic modalities as components of the aftercare plans for patients with SH but not for patients with SI. Doctors were more likely than nurses to make use of statutory community mental health services for patients presenting with SI. Both disciplines frequently returned a patient with SH to the primary care team already involved

without additional follow-up arrangements. Lastly, both professional groups were found to use the voluntary sector sporadically.

#### **5.4. Summary**

This chapter explored three areas: making sense of SI and SH, risks formulations and aftercare planning. In relation to making sense of the presentations, while most assessments following an episode of SH explored how the patients made sense of their SH, the patients' way of understanding their SI was discussed in a small number of assessments. In both groups of presentations, meaning-making was more likely to be recorded in the assessments of male than female patients. The assessments of patients presenting with SI and SH understood their suicidality as related to overwhelming emotional distress, hopelessness and mental illness. The group of SH presentations in particular referred to coping with the pain of abandonment/rejection, and some of those patients appear to have reached a point of disintegration. Klonsky (2007) reviewed the evidence for the various functions that self-injury might serve and concluded that the strongest evidence was for the functions of coping with emotional pain and self-punishment. SH has been described as a way to avoid suffering as well as a manifestation of it (Holmes, 2011). Mental pain is considered to be rooted in two sources namely adverse life events and self-destructive tendencies (Orbach, 2011) and as shown in chapter 4 negative life events was a common theme. Orbach *et al.* (2011, p.330) argue that

*'mental pain, when too intense and too enduring, is itself traumatic and can damage and even disrupt the self, sometimes driving patients to suicide'.*

Two patients described different ways of understanding and different meanings of one SH episode. Patterns in the functions of each type of SH were not found; however, the sample was small and the means of SH episodes diverse.

As for the clinicians' formulations, the majority of the assessments included some narrative about the clinicians' understanding of the function, meaning or causes of SI and SH. Whilst doctors were more likely to consider both SI and SH in the context of an underlying mental illness, nurses seemed to understand SI and SH

in a range of different ways. Most presentations across the sample appeared to have been thought of in relation to interpersonal, psychiatric and environmental problems as opposed to seeking attention or access to specific services. In relation to repetition, there was limited evidence to suggest that clinicians attempted to consider whether the meaning and motivation behind each presentation might differ from one attendance to the next.

In working with patients who SH or are suicidal, intense emotions of hostility, hatred, loneliness, rage and shame may arise which can be difficult for the clinicians to bear (Schechter and Goldblatt, 2011). Furthermore, experiences of hopelessness as emerged particularly in the assessments of patients with SH may result in clinicians struggling to hold hope for these patients. Avoiding making any emotional connection with patients and defensively focus on symptoms of mental illnesses at the expense of the patient's emotional turmoil may be seen as a way of coping in a busy A&E setting. The study of the psychosocial assessments found that clinicians attempted to some extent to engage with the patients' distress and to make some sense of their presentations which is not consistent with other findings (Redley, 2010). In these short and often one-off encounters in A&E, the therapeutic aspect of the psychosocial assessment and the concept of therapeutic alliance seem important. Roth and Fonagy (2005) described therapeutic alliance as a moderating variable without which no therapy would have positive outcomes. Schechter and Goldblatt (2011) argue that experiences of being understood and accepted by a therapist serves to alleviate the distress and aloneness in patients and thus, helps the patient to begin to bear what have previously been unbearable states. Likewise, Allen (2011) suggests that the relationship between the patient and the clinician helps the patient to experience the painful experiences related to his/her suicidal state in the context of an 'attachment' relationship in which the patient has a sense that his/her mind is held in mind by the therapist. A meaningful relationship between the patient and the clinician can help the patients to start mentalising in the midst of unbearable feelings, accompanied on some occasions by numerous social stressors, rather than being overwhelmed in non-mentalising suicidal states (Wenzel and Beck, 2008). Thus, clinicians attempts to explore patients' meaning of the presentation and



to make sense of the patients' presentations themselves appear to be central in the process of psychosocial and risks assessments in A&E.

The majority of the psychosocial assessments included a formulation that discussed the patients' vulnerabilities, unresolved states of mind and environmental factors that could maintain a risk of repeat SH and completed suicide. There was no firm consistency in evaluating risks. Broadly speaking most clinicians indicated the risk factors for repetition of SH and completed suicide. Some clinicians attempted to estimate the risk of SH/ repeated SH or completed suicide. Despite the differences, a model emerged which was applicable to both sets of presentations. The style of presenting the risk formulation differed significantly, with some clinicians drawing up lists of risk factors and others offering a narrative. Some clinicians clearly marked the section of the assessment referring to risks. Other clinicians integrated their risk assessment into a discourse of their formulation about the presentation. Clinicians did not usually differentiate between risks of repetition of SH and risk factors for completed suicide.

As for variations between professional disciplines, risk assessments completed by nurses were more likely than doctors to refer to precipitating and predisposing factors for the presentation but lacked conclusive judgements. Doctors more frequently evaluated the likelihood of further SH and/or suicide compared to nurses but they did not offer a discourse about their decision-making. It ought though to be noted that doctors appeared to have assessed patients presenting with lethal overdoses or SH that could result in death. With regards to the content of risk assessments, there were striking similarities in the factors that were used to inform the risk assessments of both patient groups (Murphy et al., 2011).

As for outcomes, aftercare plans often consisted of various elements and not a single outcome. There were similarities in the models of aftercare planning that emerged for presentations with SI and those with SH episodes. Admission as an aftercare plan was most commonly found in the presentations with SH compared to the presentations with SI. Patients' agreement with the aftercare plan was not frequently noted in the assessments. Doctors were more likely than nurses to recommend an admission. Both disciplines were unlikely to include voluntary services in the aftercare plan. Considering the findings of the previous chapter with

regards to stressful life events/ losses and patients' understanding of their SH or SI, there was a sense that there was a 'mismatch' between the discourses of patients' stories (as recorded by clinicians) and the aftercare plans offered in that referrals or recommendations to GPs for psychological therapies were rare.

## **Chapter 6- Analysis of Focus Groups**

### **6. Introduction**

This chapter will present the analysis of the qualitative data collected from two focus groups. It will describe the sample-participants of the focus groups and the procedure followed. The findings of the analysis will then be presented. Issues of fidelity in relation to the analysis will be discussed. The analysis and the presentation of the findings in this chapter are likely to be one of many ways of describing the data.

#### **6.1 Setting the Scene**

The participants were recruited through the team leader of a Psychiatric Liaison Team consisting of psychiatric liaison nurses, consultant psychiatrists and psychiatry trainees. The team offered psychosocial assessments to people who presented in A&E with SH or SI following medical assessment and occasionally treatment. All clinicians working in the Psychiatric Liaison Team were invited to participate in the focus groups. Five participants had agreed to attend the first focus group (three nurses and two consultant psychiatrists); however, one of the consultants did not attend. Hence, four individuals participated. As for the second focus group, five participants had agreed to attend (three nurses, a consultant psychiatrist and a senior psychiatry trainee,). Two of the nurses did not attend; one of them due to clinically related responsibilities. Therefore, three individuals participated in the second focus group. The characteristics of the participants are presented in table 1. The focus groups were conducted in their workplace and lasted for one hour and twenty minutes. In order to protect the anonymity and confidentiality of the participants, a pseudonym is assigned to each participant. Refer to Appendices C.6 and C.7 for the vignettes and the question routes respectively.

**Table 1. Composition of the Focus Groups**

Name	Discipline	Age	Ethnicity	Experience (years)	Experience in current post (years)	Focus Group
Anne	Psychiatric Liaison Nurse	45	White British	15	10	1
Harun	Senior Psychiatric Trainee (ST-6)	32	British Asian	N/A	12-month placement	2
Lorna	Team Leader	41	Black African	14	2	1 & 2
Marie	Psychiatric Liaison Nurse	48	Irish	23	10	1
Peter	Consultant in Liaison Psychiatry	50	White British	24	15	1 & 2

Both groups included a small number of highly involved participants that might have been difficult to facilitate at a larger size. The focus groups raised and explored additional themes to the question route regarding the management of SH and its challenges. The small number of staff in the team and subsequently, the small number of clinicians volunteering to participate in the study led to the assumption that variability within the group could be sufficiently explored in two focus groups. The difference in the membership between the two focus groups and the similarities emerging in the two groups might suggest that the group dynamics were not merely accountable for the content. Although the vignettes shared were different, the question route was similar. Therefore, there was an opportunity to explore clinical practice related to both SH and SI.

## Part 1

### 6.2. Analysis of Qualitative Content

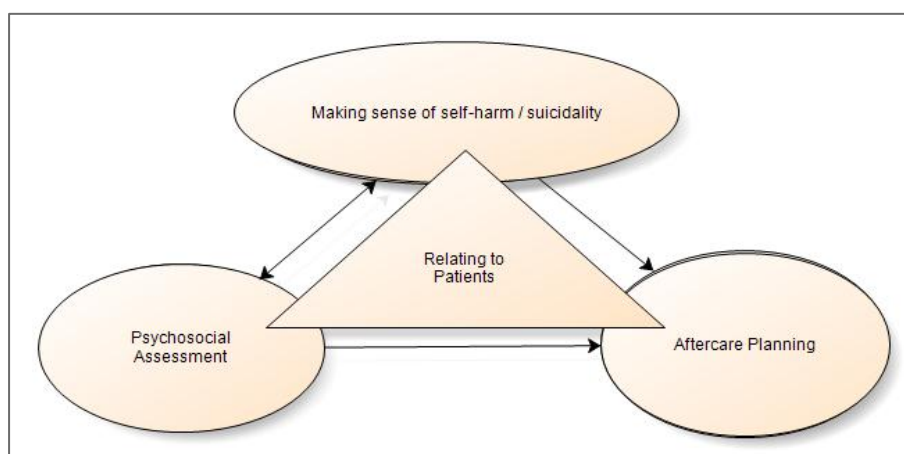
The first part presents the findings from a grounded theory orientated approach (see chapter 3) which led to the development of three levels of categories moving from specific descriptions of coded data to more general and conceptual descriptions. The first level consists of four conceptual categories, namely, psychosocial assessment, making sense of SH and suicidality, relating to patients, and aftercare planning (see

table 2). The second level is made up of thematic groups of categories within these broad conceptual categories. The third level comprises individual categories within the thematic groups. This analysis will be presented under the conceptual categories emerging with matching examples of data extracts. Considering that the question route was similar, results will be presented by identifying similarities and differences between the two groups. It is suggested that participants of focus groups can respond to questions from a range of different positions (Potter & Hepburn, 2012). Examples of this will be noted. Prior to the narrative description of the analysis, a diagrammatic description is provided in relation to how the conceptual categories inter-relate within the context of the entire focus group data (table 3).

**Table 2. Conceptual Categories**

Level 1- Conceptual Categories	Focus Group
Psychosocial Assessment	1 & 2
Making sense of self-harm & Suicidality	1 & 2
Aftercare Plan	1 & 2
Relating to Patients	1 & 2

**Table 3. Relationship between Conceptual Categories**



### 6.3. Psychosocial Assessments

This conceptual category consists of the following thematic groups: mental health assessment, liaison, involving carers in the assessment, and patients as parents (see table 4). These will now be discussed.

#### i) Mental Health Assessments

Both groups discussed the areas they would like to assess (table 4 provides a summary). The main areas they thought were important to assess in detail include: mental health history, details of what led to the presentations and assessment of SH/ SI ideation (intent and planning, hopelessness, seeking help), use of alcohol and drugs, psychosocial history, and risks.

**Table 4. Conceptual Category- Psychosocial Assessments (Level 1)**

<b>Level 2: Thematic Groups</b>	<b>Level 3: Thematic Categories</b>	<b>Focus Groups</b>
Involving Carers in Assessment		1
	Mental health	1
	Barriers	1
	Support	1
Constraints		1 & 2
	Diagnosis	2
	Funding imbalances	2
	Aftercare	1 & 2
	Time	1 & 2
Liaison		1 & 2
	Clinical notes	1
	Professionals	1 & 2
	Proxy	1 & 2
Patients as parents		2
	Assessing risk to children	2
	Decision making	2
	Introducing concerns	2
	Patient's response	2
Mental Health Assessment		1 & 2
	Illicit drugs	1
	Mental health history	1 & 2
	Mood	2
	Physical health	1
	Protective Factors	1 & 2
	Psychosocial history	1 & 2
	Self-harm /suic ideation	1 & 2
	Therapeutic process	1 & 2
	Risks	1 & 2

The need to make enquiries about the patient's psychiatric history and the need to explore repeat SH and to identify possible patterns in order to prevent further SH and suicide attempts was emphasised. Both groups were interested in exploring the circumstances around the episode and the interplay of factors leading to SH or SI.

The participants of the first focus group initially considered the presentation to be unusual due to the age and ethnicity of the patient, as well as the method of SH. From their clinical experience, Caribbean female patients of that age were more likely to overdose than to self-cut. A member of the focus group suggested that he would approach this unusual presentation by explicitly asking the patient to describe her experiences of SH and how she was led to that (see Appendix E.1).

Differences and similarities emerged with regards to exploring the current episode that led to the A&E presentation between the two groups. Both groups raised the issue of assessing intent. The first group discussed the difficulties in assessing intent when patients deflated intent and the second group discussed difficulties in assessing intent when a patient was intoxicated. One participant felt confident that a clinician could accurately assess a patient's intent. References were made to attempts to assess intent indirectly by exploring the specific circumstances around the SH episode.

*Facilitator:*            *Yes I was wondering whether it may lead back to what Peter said because in a sense you were talking about intent weren't you er and whether she, she was er honest with you, erm about her, you know, was -*

*Peter:*                 *Hmm.*

*Facilitator:*           *- it is self-harm or was it actually - ?*

*Peter:*                 *Hmm and how we make a judgment about that if someone's not really (...) being open.*

*Anne:*                 *But you can actually draw that out, you can draw that out of them in the assessment. You can wear them down until they -*

*Peter:*                 *[Laughs]*

*Anne:*                 *- you know, it depends on how much time you've got but -*

*Peter:*                 *Hmm-*

*Anne:*                 *- you can draw out the suicidality and it sometimes it's just catching, catching half a sentence of something [softly].*

*Peter:*                 *And it's sort of who was around?*

*Anne:*                 *Yeah.*

*Peter:*                 *Erm (...) what did you think it would do? What would you have*

*done if he hadn't turned up? It's, it's those sorts of questions isn't it? [Softly]*

The concepts of suicidal planning and seeking help were briefly mentioned in the second focus group as important parameters in the assessment process. The second focus group commented on hopelessness thoroughly. One participant talked about how he would attempt to explore the patient's hopelessness directly for instance, asking the patient about his future plans and indirectly, for example when he would be seeing his son next which might indicate that the patient had things to look forward to (see Appendix E.2). The second group was very focused on the alcohol misuse and one participant discussed the issue of drug use and how she would explore further the use of substance abuse as well as the meaning attached to use of drugs.

Both of the groups raised issues about the psychosocial history of patients, including activities of daily living, children and parenting, and relationship with partners and families. The themes of social support available to the patients and losses in patients' lives were key in both groups. Therapeutic aspects of psychosocial assessments were discussed in both groups. It was thought that the patient could be helped to identify current stressors that might be contributing to her/his distress. Reference was made to addressing vulnerability factors in an assessment in order to enhance the patient's hopes.

*Anne: I think if it, if it is only three weeks rent behind -*

*Peter: Yeah.*

*Anne: - and she's losing sleep over it you could actually reassure her that if it's only three weeks, some of the people we see are years behind! [High tone]*

*Peter: [Laughs]*

*Anne: You know and you can almost -*

*Peter: Hmm. Diffuse it that way.*

*Anne: Yeah and -*

*Facilitator: So there's something about her perception? Is that - ?*

*Anne: It could be her perception of the debt. I mean she might never have been in debt before but if, if the husband is drinking the money away and they've gone into debt recently and she's got no gas and electric, it's sort of putting that into a, into a proper context of -....*



Anne's nursing colleague, Marie, subsequently, highlighted the importance of the patients' subjective experiences and interpretations of events, and gently invited Anne to think about that.

*Marie: But it depends what it means to the person really doesn't it?*

*Anne: It depends on what it means to them. Yeah exactly.*

*Marie: And their ability to -*

*Anne: You know and if she, she's lived from week to week and everything's budgeted well and then she's suddenly gone into debt with the rent and stuff, it's sort of (...) normalising it and trying to - and then, and then it would be contacting the CMHT to let them know what problems there are with that. So that would be one aspect of it.*

During the second focus group it was suggested that it might be helpful to do some 'motivational work' with the patient in order for him to feel encouraged to address his alcohol use, and subsequently to be entitled to access psychological services to help him processing any difficulties related to losses and grief. As for risks, the risk of repeated SH and suicide was discussed in both groups.

## **ii) Liaison & Involving Carers in the Psychosocial Assessments**

Both focus groups discussed the significance of collating information about the patient from different sources, namely liaising with services involved, reviewing notes and gathering information from relatives. The first focus group explored the idea of involving patients' carers and families in the psychosocial assessment. They thought that it was important to involve relatives, carers and friends both in the psychosocial assessment and the aftercare planning. There were different opinions in relation to how to organise this. Two participants discussed the need to seek the patients' consent in order to involve their carers in the assessment. Another participant had a different view and suggested that the carer should be approached and asked his narrative regardless of the patient's wishes. The consultant psychiatrist highlighted the duty of confidentiality to the third party informants (see Appendix E.3). Another participant referred to patients' right to make decisions for themselves when they had the ability to do so. Participants appeared to represent different positions in relation to this theme. Whilst the nurses seemed to be speaking as individual clinicians, the

consultant psychiatrist seemed to offer answers that reflected a combination of positions including medical, organisational and possibly educational by indicating that he had been teaching trainees the importance of confidentiality to third party informants.

Most participants stated that sometimes partners would almost bring their problems (for instance alcohol abuse) into the assessment room which was seen as a barrier in the assessment process. A thought was also expressed that patients' difficulties might influence their partners' difficulties and vice versa. Difference in opinion emerged in relation to whether and what support could be offered (for example, an information leaflet) to family members for their own difficulties. Two participants said that some guidance about services available could be offered to relatives. Another thought was that this would not be possible considering that they were not the actual patients assessed in A&E which was perceived as a bureaucratic obstacle. That comment highlighted how participants can respond as individuals with unique beliefs, as well as representing organisational positions. It might have revealed differences in how each discipline approached a clinical matter. A thought was expressed in both groups that family (partners and/or children) could function as a protective factor.

### **iii) Constraints in the Process of Psychosocial Assessments**

Both focus groups raised a number of logistical parameters that could potentially affect their assessment including: 1) the time of the presentation (for presentations during the night, there would be no chance of collecting information from other agencies), 2) funding imbalances with services treating people with drug dependency having more resources compared to services treating people who misused alcohol, 3) difficulties in the diagnostic process for patients with depression/low mood and recurrent use of alcohol due to the interface between alcohol and low mood, 4) no control over the aftercare and whether the treatments suggested would be delivered or not.

#### **iv) Patients' as Parents & Children's Wellbeing**

The second focus group explored the concept of children's wellbeing. The vignette contained some information about the patient smacking his son. There was initially difference in opinion with regards to the need for a child protection referral with the consultant psychiatrist (and supervisor of the trainee) stating that a referral to children's services was necessary and the psychiatry trainee positioning himself in a different way initially. This will be further discussed in the second part of this chapter. Two participants discussed how they might attempt to establish risks and protective factors by gathering information from other agencies, for instance probation. The focus group eventually concluded that a referral to children's social care was required. Their organisation was reported to have smooth and straightforward systems in place for referrals to children's social care.

*Peter: I mean, the business about the child safeguarding... given that he's recently out of prison, probably angry with the ex-girlfriend - we don't know, but maybe angry with the ex-girlfriend - is he going to use the child as a pawn and he's intolerant of the child, he's drinking heavily. I do think there's a child safeguarding dimension...*

It was shared that training had been offered and various discussions had been held in team meetings about child protection; that was one of the few occasions during the focus groups in which a sense of being together as a team was conveyed. All three participants were concerned about the potential distress caused to the patient as well as the emotional impact of this on them as clinicians. It was proposed that such an action might leave the patients 'alienated' and less well disposed towards the team. Therefore, a participant expressed the wish to not inform the patient of the referral to children's social care.

*Peter: What I'd like to do is quietly make the referral after he's gone, just raise it as a question after he's gone and say absolutely nothing to him so I do not alienate him. But I can't do that...*

At a later point, another participant shared a different view to the above.

Lorna: *...I don't think that it is right to make a referral to the authorities without informing the patient. I think there are ways of informing the patient which, in as much as is difficult, they might not like it. If I was a patient, I would rather that I am told that somebody's going to shoot me to social services rather than social services knocking on my door and saying, oh, by the way...*

Throughout the sequences related to this thematic group, both the consultant psychiatrist's and the team leader's narratives were perceived not to be merely influenced by individual beliefs, but to reflect the organisational culture.

#### **6.4. Making sense of Self-harm & Suicidal Ideation**

This conceptual category includes the thematic groups of making sense of SH and SI (see table 5). Similarities emerged between the two focus groups in understanding SH and SI, as well as differences. This is an important discussion following the findings of broad similarity of these in chapter 5. Both groups considered SH and SI in the context of significant life events (namely difficulties in relationships with partners or family) and socio-economic factors (debt or accommodation problems). Unresolved losses and complex grief reactions were seen as a factor related to SH and SI. During the second focus group an idea emerged about A&E presentations being triggered by significant stressful events that one might not be able to face and therefore, attempt to seek refuge from, such as a court hearing. SI and SH acts were also considered to be often related to mental illnesses and alcohol intoxication. Finally, the psychiatry trainee expressed the idea that sometimes patients' reason for reporting SI was to manipulate others in order to elicit specific help with their lives, such as accommodation. He said with great hesitation and with a worry that he might be judged by the other members of the focus group as well as the facilitator and co-facilitator.

**Table 5. Conceptual Category- Making sense of self-harm and suicidality (Level 1)**

<b>Level 2: Thematic Groups</b>	<b>Level 3: Thematic Categories</b>	<b>Focus Group</b>
Self-harm		1
	Alcohol	1
	Mental Illness	1
	Significant Life Events	1
	Social stressors	1
Suicidal ideation		2
	Alcohol	2
	Avoidance	2
	Mental Illness	2
	Significant Life events	2
	Social stressors	2
	Elicit Care	2

## **6.5. Aftercare Planning**

The focus groups considered the process of devising an aftercare plan as well as the contents of it. The conceptual category of aftercare planning consisted of two thematic groups, namely the content and the process of the aftercare plan (see table 6).

### **i) Processes**

Both focus groups spent time exploring treatment options. The first focus group was influenced by the following factors: achievable and realistically delivered plan considering limited resources in community mental health services, the patients' symptoms, the risk of completed suicide, evidence-based treatments, needs of family members or carers and whether their presence could support the patient's recovery or not, patients' wishes and agreement with aftercare plan. Similar factors emerged in the second focus group namely patients' wishes and agreement with the aftercare plan, presenting symptoms, eligibility criteria of each service, risks and protective factors.

**Table 6. Conceptual Category- Aftercare plan (Level 1)**

<b>Level 2- Thematic Groups</b>	<b>Level 3-Thematic Categories</b>	<b>Focus Group</b>
Content		1 & 2
	Admission	1 & 2
	Diagnostic formulation	2
	GP	1 & 2
	Liaison	2
	Medication	1 & 2
	Community Mental Health services	1 & 2
	Psychological therapies	1 & 2
	Referral to children's social care	2
	Voluntary services	1
Process		1 & 2
	Achievable plan	1
	Protective factors	2
	Carers	1
	Evidence-based treatments	1
	Risks	1 & 2
	Patient's participation	1 & 2
	Symptoms	1 & 2
	Treatment criteria	2

## ii) Content

Psychological therapies, treatment by community teams, pharmacotherapy, admission to an inpatient ward, discharge to the care of the GP were all considered as treatment options by both focus groups. Voluntary services were suggested by the doctor participating in the first focus group as an option. The consultant psychiatrist attending the second focus group thought that the team did not always state their diagnostic formulation at the end of the assessment particularly for alcohol related disorders which was important in order for patients to subsequently receive treatment. Members of the second focus group suggested that liaison with the probation officer was needed in order for him/her to take an active role in the aftercare plan and ensure that the aftercare plan would be delivered. Both focus groups conceptualised the patient's presentation and difficulties from various aspects integrating social, environmental, intrapersonal and psychiatric factors in the aftercare plan. Aftercare plans were therefore multi-modal.

## 6.6. Relating to Patients

This conceptual category is formed by two thematic groups, namely emotional states and attitudes towards patients (see table 7).

### i) Emotional States

The focus groups explored how they would relate to the particular patient depicted on the vignette and more broadly to people presenting with SH and SI. The thematic group of emotional states consists of three thematic categories: emotional responses, factors influencing clinicians' emotional responses and the emotional impact of the work on clinicians (see table 7).

**Table 7. Conceptual Category- Relating to patients (Level 1)**

<b>Level 2-Thematic Groups</b>	<b>Level 3-Thematic Categories</b>	<b>Focus Group</b>
Attitudes		1 & 2
	Coercive	1 & 2
	Confidence	1 & 2
	Curiosity	1 & 2
	Sympathy	1 & 2
	Manipulative feel	2
	Assumptions	1
	Difference	1 & 2
	Uncaring	1 & 2
Emotional States		1 & 2
	Emotional responses	1 & 2
	Influencing factors	1
	Impact on clinicians	1 & 2

Most participants of the first focus group described relating to the patient of the vignette in an emotionally blank way, which was guided by rational thinking and information gathering. They attempted to communicate that within the context of riskier and potentially, more distressing presentations they had been confronted with, this patient would not evoke such a notable emotional reaction. Indeed one participant referred to the vignette as the 'bread and butter' of their work which was perhaps interesting when considered alongside earlier instances when the patient depicted on the vignette was seen as unusual. An empathic and compassionate way of relating to the patient of the vignette was described by one participant of the first focus group due to the profile of the patient namely being fifty years of age,

Caribbean and childless. She reflected when prompted that the origin of the compassionate feelings was related to a specific cultural connection she had with that patient.

Ambivalence was primarily discussed in the second focus group in which two participants discussed mixed feelings towards the patient. On the one hand, they related in a sympathetic way towards the patient due to the accumulative difficulties in the patient's life; on the other hand they felt rather suspicious towards him considering his demand for an inpatient admission. The consultant psychiatrist attending the second focus group discussed how minimal interaction he would have with the patient of the vignette. He elaborated that previous experiences with patients who had been intoxicated had led him to this decision. He gave a narrative about a different way of relating to patients once the intoxication had been resolved when he would be interested in exploring the patient's story. The doctors attending the second focus group looked and sounded very surprised at each other's truthfulness with regards to how they would relate to the patient of the vignette.

- Harun: I suppose it's a mixture of sympathy and suspicion [laughs], I guess.*
- Peter: That's very honest [laughs].*
- Harun: Yeah, well, because I mean on the one hand you realise that this person's got serious problems but on the other hand when people are saying admission or suicide, it just raises alarm bells in your head because, you know, you do start to wonder if - how - you know, if there's a manipulative element to this... so you kind of have those mixed feelings about it. I don't know if that's [laughs] - if that's right or wrong, but...*
- Facilitator: Yeah, well- it's not about being right and wrong...*
- Harun: Yeah.*
- Peter: I mean, at 23:30 hours, with him having had eight pints that evening, I personally would err aim to keep my face-to-face interaction with him very, very brief. And I would be prepared to have a bit more of a sit down with him in the morning but at this time of night, from bitter experience, I am not going to sit and listen to the ramblings of a half-intoxicated man.*
- Harun: [Laughs] That's very honest of you.*

During the second focus group, two participants (doctors) discussed feeling uncomfortable occasionally. One participant felt this when patients threatened to



commit suicide unless they were offered the treatment of their choice (for instance, an admission). Both doctors talked at various points about being torn between the duty towards society and the duty of care towards individual patients and how those could be at times conflicting, for instance having to make a disclosure of offending behaviour or drinking when a clinician knew that this would cause distress to the patients and have a wide variety of consequences for their lives. They felt that decisions to protect the society could impact on their therapeutic alliance with patients who could become alienated and feel utterly deserted. They shared feeling uncomfortable when the ultimate decision made was not in the interest of their patients in principal but in the interest of others for example, a referral to children's social care.

Validation of patients' experiences by communicating an understanding of the way in which suicidality states were understandable given the patients' predicaments was described as a component of the therapeutic relationship in the second focus group. The participants of the first focus group discussed some factors that could shape or influence clinicians' emotional responses and ways of relating to patients. The presence and degree of suicidality and despair were named as factors influencing clinicians' responses to patients by some members of the group. Three participants shared that they felt a greater degree of empathy when they were confronted with more lethal suicide attempts and despair. Another thought was that clinicians' responses to patients depended on the rapport between the two. One participant shared a situation in which he felt empathy and an emotional connection with a patient who had attempted a suicide by taking an opiate overdose in isolation. He described that patient as a 'functioning' man who had lost his family, home and job in a comparatively short period of time due to substance abuse and mental health problems. During this discourse, the participant acknowledged the troubling feelings this patient's predicament had aroused in him. In particular he reflected upon the commonality he shared with the patient (as a white male professional with a family) and that the suddenness of his loss of everything left a disturbing sense of the underlying fragility of the individual.

Lastly, the first focus group discussed whether they -as a team and individual clinicians- discussed the emotional impact of their work and their emotional

responses to patients. Difference of opinion was expressed to some degree. One participant felt that

Peter: *I very rarely ask myself the question, "How is this affecting me emotionally? What's my counter transference, la, la, la, la?" We just don't do it [high tone]. I, I kind of might note it (...) myself as I did and shared that with you but I would not have shared that with the team and I don't, I don't hear team members talking much about that. People sometimes come in and a let off a bit of steam but we don't analyse our emotional response to the work much I would say and it's sort of brought that home to me. Certainly among the doctors we don't.*

The team leader asserted that amongst the nurses discussions were taken place particularly when clinicians returned to the office following completion of assessments and in supervision. Nevertheless, two other members of the nursing discipline suggested that despite the emotional impact of the work and feeling at times angry or frustrated, clinicians did not name their responses, recognise them or understand them.

## **ii) Attitudes**

Attitudes towards patients with SH and SI had various dimensions. Both focus groups but the first one in particular displayed some curiosity towards the patient of the vignette. Curiosity related to participants' attempts to establish whether the presenting complaint was a masked suicide attempt and not an act of SH. The concept of being coercive emerged in both of the focus groups. On both occasions that was related to the aftercare plan and clinicians' attempts to persuade the patient to agree with their recommendations. As previously noted, the first focus group unanimously seemed to hold some firm beliefs about the characteristics of those who self-harmed with regards to age, gender and ethnicity. Later on in the discussion, a participant acknowledged that assumptions are often made about patients' presentations (see Appendix E.4).

A thought was expressed about patients being manipulative and threatening to commit suicide unless they received the care plan of their choice which resulted in clinicians holding a more negative attitude towards the patients. Acknowledgment of

social and emotional difficulties faced by people who self-harmed or experienced SI led participants to have a positive and caring attitude towards patients. Some participants approached patients with alcohol problems with less caring and positive attitudes. Although both focus groups discussed a number of dilemmas and difficulties faced in their daily clinical practice, all participants conveyed confidence in their assessment skills and in their ability to deal with patients.

## **Part 2**

### **6.7. Analysis of Interactional Data**

The main strength of focus groups is the interaction between the participants and therefore, without attention to the interactions and the dynamics within the focus groups, the data may be incompletely analysed. As discussed in chapter 3, the framework for interactional data analysis suggested by Stevens (1996) was used. The coding frame devised is described in table 8. The Emotional Group Culture Categorisation System (Rothwell et al., 2008) (see chapter 3.5) was used to describe emotions in the focus groups. In order to illustrate examples of how the themes identified in the previous part of this chapter were developed through talk and interaction, basic concepts from conversation analysis and discursive psychology (Potter, 1996) were used such as adjacency pairs (see chapter 3.5). The analysis presented in the previous part through a grounded theory orientated approach showed diversity of opinion or agreements. The analysis of interactions revealed the process by which the participants changed their ideas when they were prompted to think about their work and through their interactions within the focus groups. Therefore, the two analyses (content and interaction) are considered to be complementary.

**Table 8. Process and interaction among participants (according to Stevens, 1996)**

<i><b>Thematic Categories</b></i>	<i><b>Focus Group</b></i>
Agreement	1 & 2
Alliances	1 & 2
Common experiences	1 & 2
Consensus	1 & 2
Contradictions	1 & 2
Difference	1 & 2
Emotions	1 & 2
Related ideas introduced	1 & 2
Resolving disagreements (Negotiations)	1 & 2
Silenced & Dominant views	1 & 2
Task orientated	1 & 2

### **i) Agreement & Negotiation**

There were three themes that produced consensus among the participants namely the unusual presentation depicted on the first vignette, the familiar presentation of the second vignette, and constraints faced in the daily clinical practice discussed in the second group. Agreement was reached over a number of thematic categories as named in the table below (table 9). There were occasions when the group began to discuss various issues, and subsequently, their ideas changed, as they reflected on their experiences or debated with each other.

**Table 9. Themes in which Agreement was reached**

<i><b>Themes</b></i>
Liaison -Clinical notes
Liaison –Professionals
Mental health assessment-self-harm assessment
Achievable aftercare plan
Aftercare-overwhelming risk of suicide
Patient's participation in the aftercare plan *partially
Aftercare-treatment criteria
Aftercare- turning points
Emotional reaction- feeling uncomfortable
Emotional response-process
Involving carers in the assessment- support
Aftercare- use of mental health services

Hence, initial group and individual responses changed over the period of the focus group. There were occasions when agreement might have been reached due to the forcefulness of some participants and/or participants' attempt to conform to the group. These processes were observed when the following thematic categories were discussed: exploring the psychosocial history of the patient, offering support to carers for their own mental health difficulties, and making decisions about child protection issues. This process was predominantly observed in the first focus group and more specifically in the interactions between nurses and the consultant psychiatrist.

An example is described below. Towards the end of the interview participants were asked the following question:

*Facilitator: Erm that, that's very helpful. Erm I mean I was wondering, do you think there's anything that we may have missed; something that we should have spoken about and we didn't?*

During the first focus group, one of the participants reiterated the potential impact of marital difficulties on the patient. The participant wondered whether the recurrent alcohol intake of the patient's husband had a profound impact on the relationship between the couple. She was initially in a dilemma about how much one could intervene in relation to that and she referred to a number of occasions when she was confronted with similar situations. That thought led to a lively discussion in which all participants were involved.

*Peter: That's an interesting point though isn't it 'cause he's in a department where we have an alcohol worker and a load of leaflets about local alcohol services and yet we're specifically saying that we probably wouldn't make any of that available to him at this interview -*

*Anne: Well now we have the alcohol. Yeah -*

*Peter: - because it's beyond our role isn't it?*

*Anne: - I mean it's something to think about now we've got -*

*Lorna: I suppose it depends on what the - on your conversation.*

*Marie: If he identified it yeah.*

*Lorna: Because you've had a conversation with him, it depends on what he's bringing. If he's clearly saying to you -*

*Peter: No but - well I'm, well my own view is that without booking him in as an A&E patient I'd be very uncomfortable about intervening in*

*his life.*  
 Marie: *Hmm.*  
 Anne: *Yeah.*  
 Peter: *Which is a kind of a just a bureaucratic obstacle.*  
 Anne: *Well some, some of them are very, very specific when their partners will say [high tone], "So what do you think I should do to make - you know, what can I do? I know I drink too much and I need to stop" and, and some of the very - you know, they don't, they don't go around the houses, they come straight to the point, it's almost, "What can you advise me to do?"*

In this extract, adjacency pairs were exchanged when participants shared their own thoughts and discussed their perceptions of their role with regards to this particular task. Initially, Anne expressed some agreement with Peter's point but also indicated some disagreement by highlighting that some further thought needed to be given. Lorna subsequently offered her view and responded with a preferred reaction in that she agreed with Marie. However, in response Peter revisited his earlier position in a very affirmative way and in a way that drew a distinction between him and the rest of the group. Anne momentarily responded as if she was in agreement with Peter. Peter's response challenged the perceived agreement between Lorna and Marie. In addition, although Peter did not agree with the other group members' view, he subsequently softened his reaction by acknowledging in an insightful way feeling limited by the policies, and this made the disagreement less uncomfortable. Anne, on the other hand, had momentarily agreed with Peter. However, she subsequently went on to re-introduce Marie's idea about carers who asked help for themselves by offering a longer discourse and quoting a carer asking for help in order to support her own view. That led to a new cycle of interactions, which specifically considered an example of support, the offer of information/signposting. In other words, Anne's disagreement with Peter was prefaced by an agreement, which opened a new cycle-sequence of interaction among all four participants.

Peter: *So would you give him a leaflet? [High tone]*  
 Anne: *I'd try to.*  
 Peter: *I don't know, it's difficult isn't it?*  
 Lorna: *Hmm. If somebody ...*  
 Marie: *If he said, "I would like alcohol" [high tone] - I would like, I would like alcohol [softly] [laughs], "I would like [laughs] help with my*

*alcohol”, I could say, “Well do you know local services?” and he might go, “I’ve no idea where they are” and I’d say, “Well I can give you information on that”.*

*Peter: Okay, okay, alright.*

The interaction above illustrates that there was initially diversity in the group with regards to responding to carers’ own difficulties. The exchanges of agreement and disagreement, the way they were built and the alliances formed were an example of how the focus groups approached some ideas. On this occasion, eventually there was an agreement. It is though uncertain whether it was an agreement as such or a closing placatory comment considering that resolution seemed unlikely. This was only an example and similar sequences were present in both groups.

## ii) Difference & Disagreements

Participants displayed diverse perceptions in relation to a wide variety of topics in both groups (see table 10).

**Table 10. Themes in which there was Difference & Disagreements**

<b>Themes</b>
Liaison –Proxy
Assessing risk to children
Introducing child protection concerns to patients
Making sense of suicidality in the context of mental illness
Making sense of self-harm in the context of psychosocial stressors
Aftercare plan- mental health services
Aftercare plan- voluntary services
Aftercare plan- patient's participation
Aftercare-carers needs
Aftercare- GP
Emotional impact on clinicians
Emotional response to patients

Difference was expressed in various ways including stating difference of opinion clearly, interactions that indicated some shifting but nevertheless an unresolved difference, and differences not expressed directly after the comment one participant had made or as a matter of fact addressing the other participant.

- Harun: *With regards to the child protection ... it does raise some concerns because of what's going on in his life outside of that. But I mean, I think that I would probably - say if I was speaking to the probation officer then kind of discuss it with them and see if that had been thought of. I suppose if we're worried about the risk to the child because of his forensic history, or because of his drinking or whatever, stuff that the probation officer might have a view on, it might - people might have thought about that before.*
- Peter: *But the risk is in all these inquiries that professionals think, well, maybe the other person has thought about it already, or maybe I can just have a word with the probation officer and then leave it with them to do the - it's this whole new culture that child safeguarding is everybody's business and you have to deal with it and you have to make the referral...*

Harun expressed a different evaluation and offered a narrative about his decision. Peter had previously strongly expressed concerns about the safety of this child. His supervisee responded to his comments with a variable opinion. In turn, Peter responded with a rather strong formulation, the use of 'all these' and the high tone of his voice possibly indicated an investment in his claim, which might have produced an environment in the focus group in which the other participants did not feel able to share their diverse views. Lorna distanced herself from Peter and made no direct comment; she went on to express a different strategy to that of Harun's in her attempt to evaluate whether the child's safety was endangered.

- Lorna: *I will try to contact mum just to find out why and then try telling - I mean, I have - I don't - personally um I don't think that it is right to make a referral to the authorities without informing the patient. I think there are ways of informing the patient which, inasmuch as is difficult, they might not like it but if I was a patient I would rather that I am being told that somebody's going to shove me to social services rather than social services [laughs] knocking on my door and saying, oh, by the way um, yeah.*
- Facilitator: *I guess perhaps a dilemma is raised...*
- Lorna: *Yeah.*
- Facilitator: *...about not - not putting the relationship with the patient at risk...*
- Lorna: *Yeah.*
- Facilitator: *...but at the same time making sure that the child is okay, hmm?. As well as, as the-*
- Lorna: *The child is okay, yeah.*



Harun: *Then - I mean, if this child's living with his mother most of the time - so I'm not sure he would be a child in need, as such.*

Peter: *We don't know. 'Cause he's having problems - I mean, we don't know if it's unsupervised contact for the whole day - you don't know. Could he be drinking while the kid is with him and then hitting him? That's the scenario it points to, isn't it?*

Harun: *It could. I mean, I suppose that is a possibility...a referral.*

Peter and Harun understood child protection in a different way and assessed the situation differently. They interacted with each other indicating difference. Lorna was partly in disagreement with both of them. Lorna's talk was very often addressed to the facilitator rather than to her colleagues. Harun eventually downgraded his formulation. Nevertheless, he only agreed that it could be a possibility. The accounts used in the exchange of adjacency pairs reflected to some extent the complexity in making decisions about child protection issues. They certainly illustrated uncertainty as well as some negotiations.

### **iii) Similar Experiences**

Similar experiences among participants emerged in both of the focus groups. The following extract illustrates the role similar experiences can have with regards to devising aftercare plans.

Peter: *Er so for example people who are dragged out from under tube trains I pretty much always admit them to mental health wards regardless of anything they say to me.*

Facilitator: *Okay and, and that's because you -*

Peter: *Because I perceive that the risk of completed suicide is overwhelming -*

Facilitator: *Yeah. Uh-huh.*

Peter: *- and it just trumps all other considerations.*

Facilitator: *So there's something about the lethality of, of that?*

Peter: *Yeah. Yeah.*

Anne: *It's also to do with the time that we will see somebody after the, the, after the action, if they've been pulled out from under a train and brought into A&E, medically cleared in an hour, two hours, you go and see them and they sort of say, "No everything's, everything's changed, everything's marvellous -*

Peter: *[Laughs] Yeah. Yeah. And there's no way.*

Anne: *- now, the, the sun is shining and I feel great!" [High*

*tone]. Actually they walk back outside into the sunshine and from my view the same as yours -*

*Peter: Nothing has changed.*

*Anne: - is that they're going to go straight to a railway station and get the thought to do it again. Get the impulse to do it again so -*

This sequence demonstrates interaction characterised by consensus and shared experiences. For instance, when Peter talked about overwhelming risk of completed suicide, Anne accepted the invitation by elaborating and adding the concept of deflated or fluctuating suicidal intent. Peter positively agreed and Anne moved on to clearly indicate a shared experience in their clinical practice. In this interaction, the flow between the participants was smooth. The participants tended to take over or complete each other sentences and seemed to fully understand and agree with each other.

Common experiences were shared in the first group with regards to the following themes: considering carers needs in the process of aftercare planning, exploring the SH act and more specifically assessing intent, considering overwhelming risks of suicide in the process of the aftercare planning, and feeling the presentation of the vignette was unusual. Similarly, common experiences were found in the second focus group. Those were associated with the following themes: assessing mood and constraints in the diagnostic process, balancing risks with protective factors, turning points in the psychosocial assessment, clinician's emotional states and more specifically feeling uncomfortable, patients' responses to child protection referrals and use of admission in the aftercare planning and more specifically CDUs.

#### **iv) Emotions**

The emotional responses of the focus groups and the themes those were related to have been summarised in Appendix E.5. Dependency refers to expressions of reliance, desire for direction or compliance with the group and was observed in both focus groups (Rothwell, 2010). The most striking appeal for support was made by one of the nurses, Anne when the participants were asked to consider whether any emotional response was evoked by the patient of the vignette and more broadly

patients presenting with SH in A&E. Anne answered firmly negatively; her 'No' was accompanied by a small laugh. She subsequently glanced at the other participants in an effort to gauge some mutual support.

The extract below refers to how the group attempted to make sense of the presentation and the presence of SI in the patient of the vignette. The psychiatry trainee indicated that the patient's suicidality had been associated with a personality disorder. The consultant psychiatrist formulated the presentation differently and considered it in the context of a depressive illness. Nevertheless, he acknowledged the limitations of his formulation. Both the consultant psychiatrist and the psychiatry trainee tolerated difference well. Although the term '*competing hypothesis*' was used, the tone of the consultant psychiatrist's voice and his facial expression indicated that he was careful and hesitant in expressing a diverse view. The psychiatry trainee on the other hand immediately complied with his supervisor.

- Peter: ...one hypothesis I had is that he's not got a personality disorder at all and life was not too bad until his mum died.*
- Facilitator: Okay.*
- Peter: And then he's had a terrible sort of depressive illness since which he has self-treated with alcohol. And that's led to his decline in functioning so he might have - we haven't got a more distant personal history. So another hypothesis is that he was doing quite well in life, or reasonably well. Um, I mean, the only thing against that is, of course, then it doesn't explain the overdose in 2005 and what was it about.*
- Facilitator: This is what you were saying, isn't it?*
- Harun: And the cutting.*
- Peter: Cutting, but we don't know how far away that was.*
- Lorna: [Coughs].*
- Peter: So, you know, that doesn't fit with it [tapping on table].*
- Harun: But even if he...*
- Peter: But if he wants to be provocative, you could say maybe...*
- Facilitator: What would you...*
- Peter: ...you know, and you'd say, you know, he's not - it's not on - you see, if you wanted to be provocative you could say you've got to be careful not to...*
- Harun: Oh absolutely, yeah, so you wouldn't want to jump to a conclusion...*
- Peter: Yeah, so that's - so it's a competing hypothesis.*
- Harun: ...but that, yeah, certainly part of the differential [diagnosis]...*
- Peter: Yeah.*

There were statements that expressed reliance on external authorities to the membership in the group, procedures and structures.

Statements of fight are associated with expressions of criticism, hostility, agitation or argumentativeness (Rothwell, 2010). While hostility or criticism was not obvious in the focus groups, interactions conveying argumentativeness were more often observed in the first focus group. An example of expressions of fight was found in the first two sequences presented in the section of Agreement and Negotiations. The consultant psychiatrist eventually offered a statement of agreement which was though perceived as an expression of compliance with the group. Hence, that sequence, like others, was found to involve a combination of fight statements that perhaps led to statements of dependency. Statements of fight were very rarely found in the second focus group.

Counter-dependency statements express rejection or independence from leadership and authority (Rothwell, 2010). Although the team's figure of authority was present on both occasions, the focus groups did not show signs of being dependent on or following her leadership; neither did she exercise her authority. The consultant psychiatrist attempted to take a leadership role in both focus groups. Whilst the membership of the first focus group did not allow him to exercise any leadership, he might have managed to take a position of leadership during the second focus group. The team leader expressed in a very subtle way her independent mind; an example of that was demonstrated in the extracts provided in Part 1 paragraph 6.3.iv.

The first focus group initially approached the vignette by using the amassed reality of its considerable front-line experience to challenge the legitimacy of a case vignette presented to them as part of research. That position shifted as the discussion progressed; however, the initial response could be viewed as an expression of counter-dependency in relation to the facilitators.

Flight statements are defined as expressions of irrelevancy, isolation, or evasion to the task (Rothwell, 2010). Both of the focus groups maintained focused on discussing relevant issues with regards to the management of SH and irrelevant matters were not raised. Nevertheless, there were occasions when group members'

found it difficult to make a connection with what was previously said and changed the subject radically making unconnected comments. Flight statements were not observed in the second focus group.

Flight-pairing statements are expressions that disclose non-intimate information about oneself, but are irrelevant or avoidant of the task (Rothwell, 2010). There was a sense that both focus groups initially approached the task in an avoidant way which ceased as the discussion developed. In the first focus group, the participants offered some information about their work but were initially keen to invalidate the vignette. Likewise, the second focus group commenced by intellectualising the vignette and making comments about the epidemiology of presentations with alcohol and drug dependency in A&E, and funding imbalances.

Pairing statements are expressions of friendship and support between participants (Rothwell, 2010). Those were found in both focus groups and in principal conveyed supporting each other's comments. In the first focus group statements of support were most often observed between the two nurses. Pairing statements were equally frequent in the second focus group but more between the doctors.

Finally, counter-pairing statements delineate expressions that avoid intimacy and/or personal information (Rothwell, 2010). This was infrequently found in both focus groups. During the first focus group, the participants found it rather difficult to talk about their emotional responses to SH and patients. The consultant psychiatrist attending the second focus group offered a narrative about how he would relate to the patient of the vignette and more broadly to people attending with SI and alcohol intoxication; however, he did not talk about his own emotional responses.

#### **v) Dominant Views & Silent Members**

There were participants who were quieter than others and inevitably some participants dominated the discussion at some point (tables 11 and 12). The team leader spoke the least compared to other participants in both groups. The consultant psychiatrist, another participant with leadership role, made various bids to dominate the discussion. During the first focus group, he was often interrupted by the nurses, who on a number of occasions approached the assessment and management of SH in a different way.

**Table 11. Participation in the first focus group**

<b><i>Participants</i></b>	<b><i>References</i></b>
Lorna- Team leader	99
Anne- Nurse 1	156
Marie- Nurse 2	122
Peter- Consultant Psychiatrist	144

The picture in the second focus group was different with the consultant psychiatrist being more successful in dominating the discussion. The team leader offered her comments, which very often added another perspective to the discussion and occasionally shifted the discussion and the doctors' thinking. The supervisee-psychiatry trainee had on a few occasions a different way of approaching the assessment and management of people attending A&E compared to his supervisor.

**Table 12. Participation in the second focus group**

<b><i>Participants</i></b>	<b><i>References</i></b>
Lorna- Team leader	89
Harun- Psychiatry trainee	106
Peter- Consultant psychiatrist	122

Both focus groups attempted to 'silence' comments made by not engaging with an idea expressed by a member and in turn introducing another point which subsequently shifted the discussion.

#### **vi) Task Orientation**

Both focus groups engaged with the questions asked. Although some topics generated a more lively and lengthy discussion than others, there were limited diversions from the questions asked. While the first focus group produced more hesitant and reciprocal responses, the second focus group's questions were met with more definite, discursive and confident responses. Although the first group engaged in reciprocal interactions among participants, the participants of the second focus group often directed their comments to the facilitators.

## **vii) Contradictions**

In the previous part of this chapter, an extract demonstrated how one of the nurses, Anne initially thought about how to support the patient during the psychosocial assessment and whilst in A&E (6.3.i). The extract demonstrated how her nursing colleague, Marie drew her attention to the different way people perceived the world and difficulties occurring. Marie later on in the course of the discussion joined in to reaffirm the team leader's speculations about the patient of the vignette and her financial state. The team leader was rather unwilling to believe that the financial difficulties were causing distress to the patient.

- Lorna: I suppose what's interesting is the fact that she erm, they're both on benefits.*
- Anne: Uh-huh.*
- Lorna: I'm assuming they, they're both unemployed and I don't know whether they've ever worked before (...) and I want to imagine that there is something ... what would strike me out of the case is (...) well it's again it's an assumption, if you are on benefit and you're unemployed, three, three weeks in rent arrears is -*
- Marie: Not gonna be much money.*
- Lorna: - not -*
- Marie: £15.*
- Lorna: It's [laughs] no, not that, it's not going to be, it's not going to have such a huge impact. So you, your lifestyle would probably be pretty used to, you know, not having gas and not having running water, that kind of stuff. Again it's all assumption so to me, to then see that this is triggering or kind of contributing to somebody becoming really depressed and self harming, there is something which doesn't quite fit.*
- Marie: Yeah*

There are different ways of thinking about the process on this occasion including social desirability on both occasions or shift in thinking. In any case, it depicts contradiction between how the nurse thought about this patient in a previous sequence/ interaction with another colleague. Although the first focus group initially seemed to doubt the plausibility of the vignette as in their experiences Caribbean females of that age rarely cut themselves, in the course of the discussion they started exploring the idea of a suicide attempt and the idea of a patient concealing or deflating suicidal intent. As for the second focus group, although one participant, the

team leader initially dismissed the patient's request for an admission thinking that it was not justifiable on medical grounds, later on she suggested that this could be offered considering that this intervention had not been tried previously. The two other participants followed this shift and engaged in thinking how an admission could be organised and what the hopes would be. The previously mentioned interactions were coded as contradictions; however, they might well reflect progress in their thinking and views.

### **viii) Related Issues**

As indicated in the first part, the focus groups raised and explored additional themes to the question route which were related to the management of SH and SI, and its challenges. In the first focus group those included a discussion about intent, and a thought expressed by one participant that recurrent SH was less worrying than suicidality. In the second focus group there was a long discussion about constraints during the psychosocial assessment. Although the vignette was designed in a way that some constraints would be obviously discussed, additional difficulties emerged namely negotiating with medical doctors about admissions and difficulties in formulating a diagnosis.

### **ix) Alliances**

Alliances between the two nurses were observed at various points in the first focus group which did not often allow the consultant psychiatrist to dominate the discussion. There was one occasion when the three female nurses seemed unified against the male psychiatrist. Although this was one team, the consultant psychiatrist and the team leader drew a clear distinction between the way doctors and nurses dealt with the emotional impact of the work which revealed a loose sense of team work. In the second focus group, the doctors formed a closer relationship and alliances leaving no room to the team leader to share her views. Professional identities were noted to primarily influence alliances among participants.



## 6.8. Fidelity

Guba and Lincoln (2005) suggest four criteria for establishing fidelity of the data analysis namely credibility, dependability, transferability, and conformability. With regards to credibility, similar issues and dilemmas were raised on both occasions. A question route as opposed to a topic guide was used so that there is some consistency between the two focus groups. Both focus groups were explicitly asked towards the end of the discussion:

‘Is this a plausible vignette? Did it sound real?’

There was consensus that the presentation depicted in the first vignette was unusual with regards to the ethnicity (Caribbean), age (49), time of presentation (11:20am) and method of SH (superficial lacerations). Nevertheless, they unanimously thought that the vignette was plausible. The focus group regarded that the patient of the second vignette was familiar and recognisable to them. A summary of the findings was shared with the participants and they were invited to comment on the findings. They did not propose any amendments. Data were gathered through other methods, which allowed some comparisons. Finally, there was a lengthy debrief with the co-facilitators.

As for dependability, a major limitation is that the data were analysed by one person only. Due to organisational difficulties it was not possible to use the same room on both occasions; the same conditions were used otherwise (facilitators, method of recording, introductory statement etc). Moving on to transferability, the presentation of the findings included direct quotes which could allow readers to make their own inferences. Choosing when to quote a comment by an individual participant or a sequence of interactions depended on which relayed a theme more clearly. When two or more quotations were thought to be equally helpful, the shortest was chose. The sample and setting were described. Lastly, in relation to confirmability, the methodology section offered a detailed account of the method used.

Other factors related to the specific use of focus groups need to be thought with regards to fidelity. It is acknowledged that the participants had relationships with each other prior to the focus groups and will have after the focus groups. Hence, the participants who attended the two focus groups might have modified their participation according to that and participants in the focus groups might have

responded both to the ideas shared as well as to the people sharing those ideas (Hollander, 2004).

## **6.9. Summary**

This chapter has detailed the findings from initial analysis of data gathered through focus groups. The analysis of the content yielded four conceptual categories, namely psychosocial assessment, making sense of SH and SI, aftercare planning and finally, relating to patients. Similarities and differences were identified between the two focus groups and a clear pattern emerged in the way both SH and SI are assessed, understood and managed. The focus groups conceptualised patients' difficulties integrating psychiatric and psychosocial factors, which they took into consideration in the aftercare planning. This is consistent with the importance of addressing social/environmental factors in A&E assessments for patients (Hunter et al., 2013) and the known contributory factors to SH and SI. Dartington (2010) suggests that there is a pervasive underlying dynamic of fragmentation between health and social care in systems caring for vulnerable people. Whilst both focus groups indicated that they had no control over the aftercare process and how services will deliver support, there was a definite sense that there was a culture of attempting to integrate the health and social needs of the patients in the aftercare plan.

During both focus groups but primarily in the second focus group, it transpired that participants were preoccupied with managing organisational and national regulations. The second focus group in particular showed a strong dependency culture (Bion, 1961) to procedures and guidelines about child protection. As the discussion progressed there was an acknowledgment of the risks of following these guidelines rigidly and the need for the Team to think further of how to implement the guidelines. Various factors may have influenced how clinicians approach child protection and not least possible anxieties in the organisation as a whole (Trust) about failures. These anxieties may have possibly been fuelled by the wider societal system and the current culture of attributing responsibility for failures to individuals without attention to systemic problems which gives rise to poor public service-

provision (Rustin, 2004).

Attitudes seemed to be dimensional and mixed with both positive and negative connotations as well as ambivalent views. Individual attitudes were not always found to be reflected in the focus group's overall attitude and diversity was evident. Emotional responses to patients also varied and were primarily influenced by patients' characteristics and the degree of despair and suicidality. Various writers have commented upon the intense feelings that clinicians working with people with SH or SI may experience such as hostility, anger, anxiety, hopelessness or helplessness (Bell, 2008; Motz, 2009b; Schechter and Goldblatt, 2011). The difficulties in assessing intent and being able to predict repeat SH or suicide may cause clinicians to feel anxious about their task and competence. These feelings of anxiety may become more profound in the context of organisational structures and targets/survival rates that serve as a defence of the organisation against any possible blame, rather than acceptance of the complexities of the clinical task (Bell, 2008).

There was difference in opinion in the first focus group with regards to whether and how individual clinicians and the Team as a whole processed the emotional impact of their work. The consultant psychiatrist asserted that this rarely happened and stressed the need to revise the arrangements for supervision and team discussions in order for this to be addressed. The two nurses appear to agree with that but the team leader strongly disagreed defending the organisational structures of supervision and risk management. During the second focus group, the consultant psychiatrist and the psychiatry trainee were genuinely surprised at each other's honesty in describing their emotional responses to patients which was perhaps an indication that these are not thought through routinely. The previous chapters discussed the impact on patients when clinicians remain withdrawn or unaware of their emotional responses. Bell (2008) highlights the need to make sense of the patient's inner world and the clinician's response to this as failing to understand these can result in irrational management based on countertransference enactments. Both the consultant and the nurses alluded to an organisational culture of not being invited to reflect upon their emotional experiences. This could be thought of as an organisational defence against anxiety (Menzies-Lyth, 1960) in which anxiety is

displaced from the painful and anxiety provoking experiences of working with SH and SI to a procedural focus on risk management through supervision.

Participation in focus groups is a complex phenomenon that is influenced by the participation of others as well as individual and group-level factors (Bonito, 2002). The analysis of the interactional data identified how themes were negotiated and constructed, and how group interaction closely related to the content of the data (Hyden and Bolow, 2003). Participants' views did not always remain static but changed during the discussion. Krueger (1998) uses the term internal consistency to describe this. However, as previously indicated, this shift could be attributed to various factors namely, social desirability, forcefulness of other participants or being persuaded by other participants' views.

A marked difference between the two focus groups was the high level of argumentativeness or fight statements (Rothwell, 2010) observed in the first focus group. Pairing or expressions of support (Rothwell, 2010) between participants were equally present in both focus groups. While pairing statements were predominately observed between the two psychiatric liaison nurses in the first focus groups, those were noticed among all three participants in the second focus group. Davies (2000) suggests that nurses and doctors more often work 'alongside each other' rather than together. This is attributed to the differences in their training with medicine emphasising expertise, autonomy, and responsibility more than interdependence, and nursing emphasising hierarchy and bureaucratic rule following (Davies, 2000). A study of a multi-disciplinary team in an inpatient psychiatric ward found that clinicians in order to protect their role, attempted to protect role boundaries and functions, and therefore, the concept of working together to address the patients' complex difficulties did not occur (Jones, 2006).

Dartington (2010) refers to mature or healthy dependency in organisations in recognition of the limitations and describes it as individuals' capacity for attachment, trust and reliance on each others as well as self-reliance. Both focus groups did not always convey a sense of team working and the culture of Me-ness was sometimes evident. The basic assumption Me-ness (Lawrence et al., 1996) occurs when individuals appear to be only conscious of their own personal boundaries, which they believe have to be protected from any invasion by others and they, therefore, act as

if the group does not exist because if it did exist it would be the source of persecuting anxieties. This culture defeats the multidisciplinary working aims of mutual support for each other, and enrichment of patient care (Hinshelwood, 2010).

## **Chapter 7- Consultation with Service-Users**

### **7.1. Introduction**

As discussed in the second and third chapters research has much to gain by involving service-users with regards to increasing the relevance of the research; better recruitment to studies; insights in interpreting results; better dissemination of results (Szmukler, 2009). In this study, service-users were involved in an attempt to enrich understanding of how SH and SI are treated in A&E and to offer their views and insight on the analysis and interpretation of research findings (Faulkner, 2011). A consultation event was held in which service-users were presented with key findings from the focus groups with the clinicians, and were subsequently asked to comment on those findings. It was envisaged that service-users would share ideas and perspectives about the findings that were distinct from the researcher's. This chapter will present the findings of the consultation event.

A pre-existing group of service-users was approached. Eight members attended the consultation event, which consisted of seven service-users- people who experienced mental health difficulties, and a carer- a parent of a young person with mental illness. The group consisted of six male members and two female members. In terms of ethnicity, one member described himself as Irish, one as Indian, five as White British and one as White. The members' age ranged from 43 to 71 years. The co-ordinator of this group also attended the event. A group interview methodology was used for the consultation, which lasted for approximately two hours and a co-facilitator who is a clinical psychologist and had previously conducted research in SH with adolescents, was present.

The group was presented with three key themes that emerged in the focus groups with the clinicians. Anonymity and confidentiality with regards to the findings shared was maintained during the consultation event. A question route had been developed exploring the following themes: involving families and carers in the process of the assessment, clinicians' attitudes and relationships with patients, and aftercare. It was not possible to share with the service-users all the themes that

emerged in the focus groups with the clinicians and to seek their views in detail. Hence, the decision to share these specific findings or themes was based on the following criteria: high frequency of a theme occurring in the data, most participants having talked about a particular theme, and wide-ranging discussions about a theme. In addition to these parameters, the theme of involving carers in the psychosocial assessment was chosen due to the high intensity of comments made during the first focus group; all participants talked with a special interest in and emphasis on that theme. The theme of relating to patients was found to be central in the analysis and to be associated with all other themes. The service-users' consultation group raised and explored additional themes to the question route. Although the plan was to share with the group the dilemmas raised by clinicians in relation to child protection, the consultation group was highly involved and interested in commenting upon the relationship between service-users and professionals. Thus, it was decided to not discuss that theme due to time limitations.

Whilst the consultation event did not constitute research in itself, the analysis of the transcript was based on the principles of thematic analysis (see chapter 3). It was analysed using a different method to the one followed in the focus groups with the clinicians as the objectives/aims were different. The model that emerged from the data consisted of two levels of categories developed during coding. The first level consists of four thematic groups of categories, namely A&E treatment, carers and families, understanding SH and aftercare (see table 1). The second level comprises individual categories within the thematic groups.

All members completed a short post-consultation questionnaire which gathered basic demographic information and experiences of the event. A document which summarised the discussion based on the transcript and this chapter were shared with the members of the consultation group. The members' responses and comments were subsequently invited. In this chapter, service-users' comments will be assigned to individuals anonymously, hence individuals will not be identified. In order to protect anonymity and confidentiality, I shall refer throughout the document to 'he' rather than he/she irrespective of the gender of the contributor.

**Table 1. Consultation with Service-Users: thematic analysis**

<b><i>Thematic Groups</i></b>	<b><i>Thematic Categories</i></b>	<b><i>Number of times a theme was coded</i></b>
A & E Treatment		
	Attitudes	25
	Joint treatment	3
	Language	6
	Making sense of clinicians' attitudes	7
	Record keeping	4
	Relating to patients	9
	Risk Assessment	3
	Training	4
	Lack of specialist services	4
Aftercare		
	Follow up	8
	Invasive aftercare	3
	Limitations	9
	Patients' wishes	3
	Risk Agenda	4
	Treatment Modalities	7
	Treatment Options	3
Carers & Families		
	Carers' Needs	4
	Change in perception	3
	Change in relationships	11
	Consent	5
	Helpful	4
	Lack of relatedness	3
	Support	5
Self-harm		
	Forms of self-harm	5
	Making sense of self-harm	41

## **7.2. Process of Psychosocial Assessments**

The group was presented with the following extract from the first focus group conducted with the clinicians:

*This is quite different now, what we're going to do. I'd like to read to you a part of the discussion we had with the psychiatrist and the nurses about an assessment of a lady who was 50. She turned up at A&E with having cut herself. She said to the person that she saw that she did that because she was feeling so stressed out and so tense, that she just used a knife to release her tension. The other thing that she was worried about, and related to the tension was the fact that she was having quite a lot of financial difficulties and she felt that she was behind with her rent. So this is part of what a nurse thought she should do with this lady when they met.*



*The lady had three week's rent that she hadn't paid so the nurse started saying, "I think if it is only three weeks' rent behind, and she's losing sleep over it you could actually reassure her that if it's only three weeks some of the people we see here are years behind. So there is something about her perception. It could be that her perception of the debt is that. I mean she might never have been in debt before but if the husband is drinking and they have gone into debt recently because of the drink and she's got no gas and no electricity, it's important that she puts this into the right context. I mean, it's obviously affecting her so I would try and go into actually how much it is. You know and you can almost-"*

*"Hmm. Diffuse it that way", the psychiatrist responded.*

*And another nurse added,*

*"But it does depend what it means to the person, really, doesn't it?"*

*and the nurse responded,*

*"Yes it does, it depends on what it means to them, exactly."*

*This is part of an assessment of what a nurse felt in this case. I wonder what are your thoughts hearing this part of the discussion about the way the clinicians related to the patient? (facilitator)*

The following themes emerged as a result of the group's detailed discussion.

### **i) Relating to Patients & Clinicians' Attitudes**

The service-users highlighted that psychosocial assessments have a therapeutic aspect as talking about worrying thoughts and difficulties was considered to be a way of alleviating and dealing with distress as well as releasing potential tension. For that reason, all members of the group stated that the relationship between patients and professionals is crucial in the process of a psychosocial assessment. The above extract was perceived to be an unhelpful way of approaching and thinking about a patient's difficulties by most members of the group.

*'She's obviously very worried that she's missed three weeks' rent. Was it the nurse or doctor who said, "Oh well, some people have missed so and so?" That's not going to help her. That's not the sort of thing you tell someone. "Oh well, you're all right, you've only missed three weeks, they've missed ten weeks." You don't tell them that. Do you? No'. (Service-User 6)*

Four members of the consultation group felt that this extract demonstrated that clinicians struggled to understand the experiences of people who SH, and to subsequently relate to them in a meaningful and helpful way in the process of the psychosocial assessment.

Several ideas emerged in relation to the qualities and attitudes clinicians needed to have in order to be able to offer an assessment that was a helpful and meaningful experience for the service-users. Firstly, a caring and respectful attitude towards service-users was thought to facilitate the relationship between service-users and professionals, and subsequently the process of the psychosocial assessment. This idea was endorsed by most of the members attending the event. Listening to the patients and attempting to explore what reasons might have led to the SH act was stated to be essential by a number of attendants (five). Validating patients' experiences/ conveying that the patients' distress is legitimate, showing interest and being attuned to their needs were other parameters that were considered to influence the relational aspect of a psychosocial assessment. On the contrary, experiences of being judged for the SH act and disrespected were unanimously thought to hinder the process of assessment as well as to influence future A&E visits for one service user.

The group unanimously agreed that each individual perceived his life and difficulties in a unique way. Therefore, the importance of clinicians' having an '*open mind*' that wished to explore the personal experiences of each patient was highlighted.

*'Are you saying the injury to her body is disproportionate to the problem she's got? She's got some debt problems but lacerating her body isn't going to solve that. Some people react very negatively, don't they? Two people might have the same problem and one can deal with it yet the other person, it seems to go completely out of all proportion'. (Service-User 7)*

Another way of describing this was as follows:

*'Yeah, listening, everybody should have good listening skills, not interrupt, not have their own view, preconceived ideas'. (Service-User 5)*

Various members made reference to the importance of clinicians' understanding the emotional states/ experiences of the service-users and being able to communicate

that understanding in a sensitive way. Hence, the need for practitioners to spend sufficient time in order to explore the service-users' experiences was emphasised by a member of the group.

*'Time, we didn't discuss it although the idea of having empathy is kind of related ... often it does take time to learn to understand somebody. So I think one of the important points I was thinking about was the need for those who meet you in that A&E situation to spend time to actually find out what's really going on'. (Service-User 2)*

A point was made in relation to mental health professionals having very low expectations of people with mental illnesses, for instance people were not expected to be able to work again or to look after themselves. Particular reference (four members) was made to triage nurses often treating people with SH and suicide attempts in a disrespectful way as they considered the injuries to be self-inflicted and not accidental. A point was made about people with physical illnesses being disrespected and humiliated by hospital staff when attended A&E; hence, it was highlighted that hospital staff could display negative attitudes towards patients on the whole and not only towards people who presented with mental health difficulties. In addition, a thought was expressed that visiting a Hospital could be seen by some people as a risk of losing power over themselves in the event that they would be sectioned under the Mental Health Act.

*'Is that a lot of people who use the services they don't always see hospital in a positive light. A lot of people call a hospital "the bin," a dumping ground and that if you go into hospital you risk losing power over yourself, being sectioned under the Mental Health Act.? If you're seen as being a danger to yourself or other people'. And that's a big issue for a lot of people. (Service-User 7)*

Finally, a member of the group suggested that joint working between triage nurses/medical doctors and the Psychiatric Liaison Team could facilitate the assessment and treatment at the A&E. A suggestion was made about the need for education and training to be offered to triage nurses, medical doctors and specialist mental health staff working in A&E Departments in relation to how to approach and engage with people who self-harmed or attempted suicide.

## ii) Making Sense of Clinicians' Attitudes

The group spontaneously made attempts to understand why professionals might be offering care that was neither meaningful nor sensitive to patients. Firstly it was thought that it might be challenging for doctors and nurses whose job was to protect life to treat people who self-injured. This was considered to lead to clinicians conveying unsympathetic attitudes towards the patients and being unable to make sense of the patients' distress and difficulties.

*Service-User 7: I'm aware that when you go to present yourself to an accident and emergency, most people are there because they've had an accident or something, but with suicide or self-harm, it's self-inflicted isn't it? Something you do to yourself... They are not sympathetic, they say, "Well people are here because they've had an accident, you've created this for yourself." And they can be rather hard on people, they don't understand what the persons going through. They see them as the architect of their own injury. So yeah, I can understand for someone who's trying to save life, that could be a challenging concept.*

*Service-User 4: No, .....[service user 7]has made the point that I intended to make, before you get to the mental health stuff there is the stigmatisation about the fact that it's self-inflicted.*

It was suggested that other factors not related to service-users might cause a mental health professional to not offer care of good quality, for example a nurse facing difficulties of her/his own and therefore being distracted from her/his duty of care due to her/his personal difficulties.

*Service-User 6: On the other hand it could be that the nurse is maybe having an off day. But it could be her problems that she was pushing onto the patient.*

*Service-User 7: Yeah, that's what I was going to say.*

*Service-User 6: If she's having a bad day, "Oh, what about other people?" I don't know but it's possible.*

Although there was consensus that some mental health professionals could be insensitive, one member suggested that some professionals might still have good intentions for example, offer reassurance to patients, but not the skills to do that in a sensitive and meaningful way for the patients, such as the discourse the nurse of the previously mentioned extract offered. Finally, the consequences of suicides to professionals were discussed. It was pointed out by two members that psychiatrists

and nurses might be preoccupied, when carrying out assessments and making decisions about care, with the likelihood of an enquiry in the event of a suicide.

### **iii) Procedures**

Risk assessments were not thought to be meaningful by the group. Mental health professionals were thought to be preoccupied with completing risk assessments and not with attending to people's health and their emotional wellbeing which did not aid patients' recovery journey.

*'The point is they are concerned about risk, aren't they? They are not concerned about recovery, they are concerned about risk as number one. And that doesn't make you feel any better to be on the end of that.'*

...  
*The other thing is the risk agenda which is basically they've got to find something better than ... it doesn't appear like a service which is concerned with people's health. It's a service where you get into it and then the risk agenda takes over and you get further and further into that service and it's very difficult for people to come out'. (Service-User 1)*

A member of the group wondered whether mental health professionals used the risk assessment questions as a way of protecting themselves and not the patient in the event of a suicide and a subsequent enquiry.

*'I wondered how seriously the psychiatrist takes these risk assessments because they have a duty of care very much so. And also if somebody does commit suicide after they've seen them and they've released them and done nothing, they've got to face the coroner and inquest. They've got relatives and others, if they can afford a barrister they've got to face questions, because they are going to see the notes and question, "What did you do and why did you do that?" And a lot of experienced psychiatrists have that at the back of their mind. But there may be some others who haven't come across it and perhaps hadn't thought of that consequence. What are they thinking when they actually discharges somebody'. (Carer)*

Another member thought that risk assessments might not necessarily lead to meaningful follow-up treatments being offered to the patients according to the needs identified in the psychosocial assessment aiming at preventing suicides. Instead it was felt that extensive risk assessments could result in medication being the only treatment offered which was perceived as dismissal.

*‘So I can see why people commit suicide after ... well basically they are at their most vulnerable and then psychiatric services come in really, really hard and want to know exactly what’s happened. But after they’ve found out, that’s it, back to seeing the psychiatrist once every three months with some medication’. (Service-User 1)*

Some members of the group explored the process of a psychosocial assessment with regards to record keeping. A view was expressed that mental health records were kept for a long time and that could be seen as stigmatising people. Furthermore, it was thought that service-users might be at times misunderstood and the records might not always be a true reflection of what patients had shared with nurses and psychiatrists. Lastly, the lack of specialist A&E for people with mental health problems and the long waiting times were considered as factors preventing people from attending A&E by one member of the consultation group.

#### **iv) Language**

The use of language and words was discussed. One member talked about the fact that he did not like the use of the term ‘service-user’ as it did not offer a description of which service was used. He preferred the term ‘patient’. Similarly, the term ‘carer’ was not perceived well. Finally, the term ‘assessment’ had a negative connotation for one service-user. Assessment was associated with feelings of anxiety considering that assessment could be a way of scrutinising people but not offering support.

### **7.3. Involving Carers & Friends in the Assessment & the Aftercare**

The group was presented with the finding that clinicians felt that relatives, carers and friends could play a crucial role in the care and the after care of the person who self-harms or experiences SI. For that reason, clinicians felt it was important to involve relatives, carers or friends both in the assessment and the aftercare planning. As described in the previous chapter this was a very contentious theme for the clinicians with regards to how to seek the carers’ and families’ accounts. The members of the consultation group were subsequently asked for their own thoughts.

Different opinions emerged in relation to involving family members, carers and friends in the process of the assessment and the aftercare. Two members of the group discussed how the patient's relationships with family and friends could change if family members and friends were to adopt the role of a therapist. It was thought that this change in roles could affect both people involved in the relationship in an unhelpful way. Thus, it was suggested that it might be helpful for mental health professionals to encourage family members and friends to not attempt to become 'therapists'.

*'I think that's a good point, the way the relationship can change is that when your wife suddenly becomes your carer, that's very awkward. It feels as if a relationship has changed and that can create a difficulty in what would have been a good relationship. It can change it into a bad relationship because the nature of the relationship has actually changed. Particularly if you've been with somebody for a heck of a long time, you almost get your roles, don't you? And if those roles suddenly change, that affects both people and that can be really, really hard'.* (Service-User 2)

Similarly, some members of the group thought that involving family and friends in the therapeutic process might result in family and carers seeing the service-user at his worst continually. Furthermore, one member of the group expressed the view that people who self-harmed might often have no friends/ relationships/ relatives or they might experience difficulties in their relationships with their families and have family members who did not show any empathy.

*'But on the flip side of the coin many people who self-harm come from ... and this is not all but a large chunk of people who self-harm, may come from quite dysfunctional family backgrounds where there's been dysfunctional attachments and they may not have either any relationships with their parents, particularly, or even with their whole family, which is quite common in many'.* (Service-User 3)

On the other hand, three members thought that involving family members in the assessment process might be helpful considering that they could offer an insight into what might have led to SH and the meaning of it. It was shared that sometimes when patients and carers had a good relationship with each other, carers could perhaps facilitate the therapeutic process or could seek help on behalf of the patient. SH was thought to be a very frightening and distressing experience which could leave people feeling isolated. Involving carers could therefore be helpful sometimes.

*'Excellent, even if there's a consent problem, they know the person when they were well, they also should know triggers and ... they might know the actual reason why. It also becomes a shock to a carer especially if out of the blue someone has attempted suicide. And also self-harming as well, because so often that is sometimes hidden away....'. (Carer)*

The need to offer to family members and carers a space to understand mental health problems and how these could be approached was emphasised by some members. It was thought that by involving family members in assessments, a clinician might have the chance to identify difficulties in family relationships and subsequently offer an appropriate intervention. Looking at SH from the carers' and family members' experiences, a few members thought that SH and suicide attempts might be emotionally upsetting for families. It was suggested that not involving them in the assessment and therapeutic process might cause them to feel isolated. Seeing a family member to struggle with a mental illness was considered to be a bereavement.

*Carer: Just to add on that, I'm a great believer that carers should be given coaching skills if they wish and that could be involved in training. Motivational skills and things like that. But this one means that you should be given advice in the first instance, say, "Don't become therapists." And give advice on how to handle somebody because carers and partners and so on, they have seen the person and they're going to know the person and have fallen in love with that person etc. when they are well. And suddenly this happens and the actual person they feel ... and a lot of carers, I don't like the word "carer" –*

*?M: No.*

*Facilitator: What words shall I use?*

*Carer: But I'll use it anyway. When they see somebody going through an illness it's like bereavement. And if somebody has a number of episodes it's a number of bereavements and they've got to start again and there are stages that they can go through. It depends on how they handle it how long these stages last. And if you get a bit of advice in the first instance, and hope that the clinician does give that impression that there's a light at the end of the tunnel, and if they are not kept informed, they're in the dark and some people start to take control. And sometimes a service user takes control, maybe, emotional breakdown and blackmail and things like that. Or the carer takes control.*

*Service-User 7: That was the point I was going to make.*



Service-User 3: Yeah, yeah.

Finally, the group discussed the need to seek the patient's consent before involving carers and family friends. They discussed the likelihood of a service-user being unable to consent and the professionals' right to waiver confidentiality if that was required.

#### **7.4. Aftercare**

In relation to the aftercare, the service-users were asked to consider the following:

*One of the things the clinicians have very strongly in their mind was both the service user's participation but also the service user's agreement with the aftercare plan. Because usually after they've seen the person, they need some kind of an aftercare plan about what can be offered. It was about the importance of the service user's participation and the service user's agreement with the plan as opposed to making a plan without consulting the service user. I think one of the things they were most struggling to weigh up was that they felt that it was important to explain various options, what is around but at the same time they felt that it was important not to start overwhelming and bombarding people with loads of services. So it would be helpful to hear your ideas about their dilemma, the service user's participation and agreement with the aftercare.*

The importance of follow-up after discharge from A&E was highlighted by the majority of the group. With regards to treatment options, one member of the group conveyed that in his experience the range of treatment options might be massive for new patients; nevertheless, rarely were patients presented with a whole range of options in the beginning. Furthermore, he thought that the treatment options for those people who were known to mental health services for some time were exceptionally limited.

Moving on to treatment modalities, a member of the group suggested that people with psychosis and SH might not be offered a holistic treatment. It was added that people with auditory hallucinations might only be offered pharmacotherapy without psychosocial treatments, for example learning how to cope better with hearing voices. On the other hand, it was suggested that for people who self-harmed

but did not suffer from psychosis, there was no pharmacotherapy that could ‘take away the painful emotional feelings’ people had. Community mental health services were not thought to be skilled in engaging and supporting people who SH in a sensitive and caring way. Lack of specialist support for recurrent SH was also discussed by one member of the group.

*‘And the other is the non-psychotic end of the spectrum. There isn’t medication you can give to take away the painful, emotional feelings that people are having. And there isn’t even the medical teams. The psychiatric teams are just not geared up a lot of the time. They might not be gender specific, for example, or culturally aware. (...) There may be a bit of counselling short term, but long term, realistically, there’s very little. (...) Just because someone is suicidal doesn’t mean that staff become medically orientated, they try to medicate away the suicidal feelings. And we need lots more long term talking work which, sadly because of the way commissioning is going, just isn’t available’.* (Service-User 3)

Psychological therapies were seen as the treatment modalities that should be offered to people with SH in the first place as well as specialist psychological services for people with SH. There was consensus on this.

*‘Obviously with someone self- or suicidal attempts or ideation, obviously the first option is psychologist, talking therapy to get to the root of what’s happening. I think there are some people who express suicidal ideation and then admit afterwards that there wasn’t really suicide but it was the only way of expressing how depressed they were at the time’.* (Service-User 4)

A comment was made about the quality of services as opposed to the therapeutic modality or ‘quantity of services’. Aftercare that addressed the emotional experiences of service-users was seen as of supreme importance. In addition, the way professionals relate to service-users (including the encounter with the LAS and A&E) was seen as very important in the process of recovery.

A suggestion was made about producing an information sheet or leaflet with local services and treatment modalities available for SH which could be given to people at the end of the psychosocial assessment. Similarly to A&E staff, it was thought that community mental health professionals would benefit from education and training in relation to how to approach and engage with people who self-harmed or attempted suicide. It was noted that staff needed to have access to training of their interest instead of every professional being offered training in a/the most popular treatment modality.

Other limitations were expressed in relation to accessing aftercare. Firstly, the group expressed the view that people faced long waits in accessing aftercare offered by their GPs and mental health services. The delay in receiving treatment was thought to sometimes be a trigger for further SH episodes and visits to A&E. Some members underlined that a number of people might be discharged to the care of their GP. In order to access aftercare through GPs, it was thought that people needed to be proactive and make appointments themselves to see their GP which might be very difficult for people in distress. A service-user thought that this population might be at increased risk of receiving no aftercare which might consequently result in repeat SH.

- Carer:* *Maybe sometimes it maybe an information sheet would help ... be prepared to say what services there are in the location. But also often people require talking therapists and talking therapies, irrespective of what they are, you have to go through an assessment and there's a waiting time then. And there's another waiting time before you actually receive the therapy. It could be a year sometimes or longer. Sometimes people get fed up and they are in A&E because they've self-harmed again. And often people just get referred back to the GP and they leave the GP to do something but the GP would only do something if the person follows it up, makes an appointment and goes and sees the person. Often seeing your GP you have to wait three or four weeks before you get to an appointment if you are that proactive. And, of course, that's a long time.*
- Service-User 6:* *That's what I was going to say. Some people who go to A&E and say they've cut themselves, might not have hurt themselves enough to be admitted or to come back to the clinic to be dressed the next day. And that might be their first treatment as well. So what happens to them? ...[Carer]said that when you get admitted you have a seven day ...*
- Carer:* *That's not in a general hospital, that would be when you were admitted to the mental health ward and you got discharged.*
- Service-User 6:* *Because I presume the people at the A&E do drop the GP a note?*
- Facilitator:* *They would probably do that.*
- Service-User 6:* *Would a lot of these people go back actually to the GP for further referral or to see somebody. It's been a long time, I really don't know. Because they might be the ones who drop through the net and then they'll come back next time possibly.*

Difficulties and differences in accessing psychological therapies emerged with regards to locality and other parameters/ prerequisites had been experienced by some members of the group, for example whether people were ready to return to work.

*'...[Carer]mentioned talking therapy in some areas talking therapy is rationed. The preference is given to people who are ready for training and employment. And others are left behind. So those who have got a real need, they don't get that'.*  
(Service-User 5)

A member of the group discussed how assessments by mental health professionals could be very invasive for service-users when mental health professionals requested detailed information about their episodes. Similarly to A&E psychosocial assessments, it was added that despite extensive assessments sometimes the aftercare offered could be exceptionally limited for instance psychiatric reviews every three months and pharmacotherapy which was unlikely to meet the needs of service-users. Mental health practitioners were thought to focus on risk assessments at the expense of recovery which was experienced as neither helpful nor meaningful by people who self-harmed or attempted suicide.

A view was expressed that sometimes no matter how good the A&E services and the aftercare might be, there were people who would at some point in their lives commit suicide.

## **7.5. Making Sense of Self-harm**

During the consultation the group spontaneously explored the meaning of SH generally and more specifically in relation to a short vignette/example of a middle-aged lady who faced financial difficulties and difficulties in her relationship with her husband; her husband was using alcohol recurrently. SH was considered from a wide variety of perspectives.

Firstly, low mood, stress, and lack of pleasure in life were seen as unbearable and overwhelming states that may lead somebody to SH.

*‘.....whereas self-harm is inflicted and people go to A&E. It’s because people are pretty low and miserable and have low esteem about themselves and don’t have anything pleasurable to think about’. (Service-User 3).*

Furthermore, various members associated SH with difficulties in interpersonal and intimate relationships. More specifically, it was thought that SH acts could be a way of communicating these types of difficulties and associated distress.

*‘It could be many things. She could be self-harming because she’s in a position where her husband, the person she shares her life with is doing self-harming behaviour with alcohol, she can’t do anything about that, maybe she doesn’t want to leave. Maybe she doesn’t think breaking up a marriage relationship, it’s going to be awful. So what kind of situation is she in? What choices does she have? She might want to keep things going. The self-harm may be a message to her husband, Look what you’re doing to me’. (Service-User 1)*

Tension in the relationship between parents and children resulting from parents exercising their authority strictly were identified as a trigger for SH episodes by one member.

*‘I come from India, it’s quite a common thing in the Indian community, children have to do what parents want them to do. So that’s what the friction is’. (Service-User 5)*

Similarly to the clinicians, service-users considered that mental illnesses such as depression and psychosis might be associated with SH acts and suicide attempts.

*‘I think there are some people who express suicidal ideation and then admit afterwards that there wasn’t really suicide but it was the only way of expressing how depressed they were at the time’. (Service-User 4)*

Perfectionism or in other words high expectations of oneself were thought to relate to SH to some extent. A clear wish to die was considered to be sometimes communicated by SH acts by two members of the group. SH was also seen as a way of coping with emotions of guilt. The group unanimously agreed that experiences, values, and difficulties, for instance financial difficulties were subjective and had a unique meaning to each person. Spirituality was viewed as a way of making sense of difficult experiences which could help people who self-harmed or attempted suicide to *‘bounce back from that’* by one member of the group. A member of the group shared that assessment by mental health professionals, who were invasive and interrogative, could potentially lead to repeat SH and breakdowns particularly if there

is lack of follow-up support. Some members of the group raised the likelihood of various reasons contributing to despair and SH as opposed to the idea of one antecedent or trigger.

*Service-User 2: The only thing I was thinking is I suppose it's when you're ill in hospital when you've done something, often the thing that you will express first of all might be one thing which is worrying you which is behind why ... one of the reasons that you are the way that you are at that particular moment in time. It would have been good for the person to try and explore a little bit more to try and see whether that was the only issue. The chances are that very few of us have only one issue, at any rate. But there might have been something else which was particularly troubling at that time. Because it is often the thing which springs to your mind first of all you say, but there might be other things happening.*

*Service-User ?X: That's right (x 2).*

Another thought was that SH and more specifically, the visual perception of blood was seen as a way of helping somebody to feel alive and real. In addition, another member of the group suggested that suicide attempts could be understood in the context of altruism and fear of society. Lastly, a thought was expressed that suicide attempts could result in overcoming fear of death which was experienced to be life changing. As for means of SH, one thought was that tattoos and circumcision were acts of harm. The latter one was thought to be harm inflicted by the society.

*'A couple of points I would like to make that we haven't talked about very much. Tattoo is a form of self-harm that's addictive. But nobody thinks anything of it.*

*....*

*Another think I'd like to mention is circumcision. Circumcision is harm by the society'. (Service-User 5)*

Finally, one thought was recurrent use of alcohol might be seen as a way of self-harming.

## **7.6. Summary**

This chapter presented the involvement of service-users in discussing key themes of the findings emerging from the focus groups with clinicians. The service-users

highlighted findings that were most relevant to them and offered interpretations from a service-users' perspective which added to the analysis presented in chapter 6. In summary, the group offered a wide range of ideas in relation to psychosocial assessments at the A&E Departments and the aftercare. Although there were similarities and differences between the group members, offering sensitive and respectful care to people who visited A&E was regarded to be essential in the process of assessment and recovery. That appeared to be the most dominant theme emerging in the consultation. Conveying a genuine interest in and understanding of the experiences of a patient presenting with a SH episode was considered to facilitate the engagement between service-users and clinicians. All members of the group asserted that the relational aspect of the psychosocial assessment was of supreme importance which has been highlighted by various authors (Allen, 2011; Holmes, 2011; Orbach, 2008) and has been discussed in previous chapters. Most members of the consultation group viewed clinicians as unconcerned, judgemental, hostile and on occasions intrusive. The consultation group associated SH with internal distress related to primarily to mental illness and relational difficulties. Motz (2009a) among other writers suggests that SH can be understood as a way of saying through gestures and acts of violence, what cannot be put into words. The consultation group made no reference to the hostile attack on the body related to SH. Interestingly, hostility was only located in the clinicians. Chapter 5 made reference to the fact that patients who present with SH or suicidality may evoke intense emotions of anger and hostility in clinicians which may be difficult to tolerate (Schechter and Goldblatt, 2011). Nathan's point (2010) about reflective and embodied countertransference may be helpful in this regard. Nathan (2010) argues that reflective countertransference relates to patients' disowned and projected experiences of self, such as hostility, anger and distress that the clinicians are made to experience. Embodied countertransference relates to patients' experiences of hostile bad objects re-evoked, embodied and played out by the clinician as a persecuting figure reminiscent of the internal representation of the patient's inner world (Nathan, 2010).

An important theme emerging in this consultation was the way service-users attempted to make sense of the negative attitudes displayed by some clinicians

treating SH which included lack of communication skills, parameters not related to service-users and the act of SH as well as the idea that it might be challenging for doctors and nurses who strive to preserve life to treat people self-injuring. The latter comment could be thought of in conjunction with Bell's (2008) argument that mental health clinicians have a common wish to repair their own damaged objects through their work and therefore, in order for clinicians to be able to work effectively with this population, the patients' attacks on these reparative wishes would need to be worked through. Various thoughts emerged with regards to the participation of carers and family members in the psychosocial assessment.

Similarly to the focus groups with the clinicians, this theme invited the most diverse discussions and positions with limited definitive findings. The idea that had the highest intensity was the change of roles in families perceived by some service-users who strongly believed that their family members attempted to become their therapists. Finally, aftercare planning is one of the main functions of psychosocial assessments. Clear discussions about the interventions/services available and timely follow-up were considered to aid recovery. There was extensive discussion around the proposed or chosen intervention and how that needed to be consistent with the service-users' wishes and hopes for recovery. The group unanimously favoured psychological interventions that have the capacity to engage with and address the emotional experiences of the service-users as opposed to psychopharmacological treatments.

With regards to the service-users' thoughts about the event, six members of the group found the consultation very interesting and two members reported that it was interesting. In terms of how important the themes discussed were, six members considered those to be very important and two considered them to be important. As for the duration of the consultation, five members found it to be about right, two slightly longer than it should be and one slightly shorter than it should be. Finally, six members felt that their participation was very much encouraged by the facilitators and one member felt that his participation was encouraged. One member felt that his participation was encouraged sufficiently.

In conclusion, involving service-users in making sense of the research findings offered perspectives and insights, which were not previously thought of by



the student. It increased the relevance of the research (Szmukler, 2009) by highlighted meaningful aspects of the psychosocial assessments for the service-users, including how carers are involved in the assessment and treatment of people who SH, and the significance of the aftercare planning and access to psychological therapies. The latter would seem particularly important in light of the findings from the psychosocial assessments in which a mismatch was identified between patients' narratives and the lack of referrals for psychological therapies. Finally, involving service-users in making sense of the data and the findings helped the student to reflect on the research process and to ensure that her own interests and preoccupations were not imposed on the data (Rose, 2011).

## **8. Discussion**

### **8.1. Introduction**

This study aimed to contribute to the knowledge of assessing and treating SH and SI in A&E through in-depth studying psychosocial assessments and exploring clinicians' decision making process, and clinicians' experiences of this complex and emotionally demanding task by using mixed methods. The epidemiology and outcomes of A&E presentations following SH have been studied extensively (see chapter 1). Little is known about the content of psychosocial assessments in A&E for people presenting with SH and SI. Professionals' attitudes towards SH have primarily been portrayed as negative (Saunders et al., 2012) and patients often report dissatisfaction (Taylor et al., 2009). The attitudes and the experiences of clinicians working in Psychiatric Liaison Teams have not been studied in depth. This study aimed to explore:

- what are the experiences people with SH or SI narrate during psychosocial assessments in A&E? What differences and similarities exist between SH and SI psychosocial assessments in A&E carried out by a Psychiatric Liaison Team?
- what are the attitudes, feelings, and experiences of clinicians carrying out psychosocial assessments for patients who SH or present with SI in A&E?
- what is the process of the Psychiatric Liaison Team making decisions about treatment/interventions offered following psychosocial assessments?

This was attempted through collecting two types of data (documents of psychosocial assessments and focus groups) and analysing them with different qualitative methods. Service-users were involved in the process of making sense of the results. This study drew on data gathered in an earlier study of the relationship between background social factors, psychiatric diagnoses, and suicidal/self-harming histories, the treatments offered and the treatment outcomes (Briggs and Glen-Day, 2008).

This chapter will consider how far the study achieved these aims and what was learned in the process. The types of data and the qualitative methods used to

analyse them were chosen in order to address the study questions. It is an innovative approach in this field and requires evaluation, particularly with regards to analysing interactions in focus groups. The findings from studying psychosocial assessments, and clinicians' ways of approaching their task and relating to patients require consideration of theoretical approaches in order to make sense of these. These were set out in chapter 2 and will be used in this chapter in an attempt to make sense of the findings. The key areas were: theory of mental pain, psychoanalytic theories of SH and suicidality, psychodynamic perspectives in organisational dynamics and their application to multi-disciplinary teams such as the Psychiatric Liaison Team which is the focus of this study. In the discussion of the findings, some references have been made to these theoretical perspectives and this chapter will consider how far these theories proved helpful in making sense of the data.

To recap the methodology, a purposive theoretical sample of 61 psychosocial assessments was drawn from a sampling frame of 596 psychosocial assessments for male and female patients aged 17 to over 70 years old who were assessed by the Psychiatric Liaison Team following an episode of SH or SI. Inductive thematic analysis (Braun and Clarke, 2006; Joffe and Yardley, 2004) and deductive analysis using the categories of OMPP (Orbach et al., 2003a) was employed to analyse the data gathered. Two focus groups with clinicians undertaken psychosocial assessments were held using a vignette on each occasion. A grounded theory orientated approach (Corbin and Strauss, 2008) was used to analyse the content of the data. The questions proposed by Stevens (1996) were used in order to analyse the group dynamics and the interactions among participants. Finally, the main themes emerging from the analysis were discussed with service-users who offered their interpretations and comments about the analysis. The main advantage of using documents was the richness of the data, which were naturally occurring data documenting how clinicians routinely wrote about the assessments they undertook without being asked by researchers (Silverman, 2011). The main limitation could be considered to be that these were documents written based on clinicians' interpretations. The interaction between participants is the unique advantage of focus groups (Grønkjæ et al., 2011). The analysis of interactional data has been a

relatively recent development in research. Therefore, further evaluation and refinement may be required.

There is always tension in qualitative research between staying close to the data, demonstrating methodological rigour and attention to detail, on the one hand, and applying theoretical ideas when looking at the data on the other hand. This study prioritises the former, and the findings report in detail the generation of themes and categories through especially the method of thematic analysis, whilst also introducing and working with theoretical concepts and ideas to make sense of the data.

The key theoretical concepts drawn on and applied to the research were, firstly mental pain through the OMMP (Orbach et al., 2003a). Intense mental pain is experienced by some suicidal people (Orbach, 2011). A number of psychoanalytic ideas have been developed in order to describe the meaning of SH and suicidality including alleviating internal distress (Adshead, 2010), re-enactment of former abuse (Scanlon and Adlam, 2009), coping with dissociation (Low et al., 2000), and violent urges (Nathan, 2006). SH can have different meanings. Motz (2009a) suggests that it is the divided mind that characterises SH referring to the destructive act that can be seen as one that actually serves to protect the person from pain and, she therefore views SH as a means of reaching out to others.

The understanding, management and containment of patients who SH or experience SI can be a complex task for clinicians working in A&E. Nathan (2006), and Scanlon and Adlam (2009) suggest that clinicians are vulnerable to powerful negative countertransference reactions related to the violent act of SH and suicidality and thus, can be drawn into re-enactments of abuse by taking a hostile condemning stance towards the patient. Alternatively, clinicians may withdraw from the patient in an attempt to protect themselves from the feelings of hostility, anger, loneliness or intense mental pain (Schechter and Goldblatt, 2011). Menzies-Lyth (1960) introduced the concept of social defences to describe how nurses attempted to reduce their anxiety aroused by the intimate physical and emotional involvement with ill patients by becoming disengaged from the patients. This can be applicable to the anxieties mental health clinicians can experience when are confronted with feelings of anger, loss, fear, helplessness when working with SH and suicidality. The concept of the primary task (Lawrence, 2000) and Bion's theory of basic assumption (1961) are

particularly important in multi-disciplinary teams where members come from different trainings with different values, priorities and preoccupations (Stokes, 1994).

Psychodynamic ideas are chosen in order to make sense of the findings of the study as they can help clinicians making some sense of the inner world of the SH and suicidal patient, address the relational and therapeutic aspect of the psychosocial assessment, and are consistent with the research body that has identified difficulties in the early life and care of people at risk of SH and SI (Fliege et al., 2009). In evaluating the findings of this study, I shall draw on these theoretical ideas and also assess to what extent they facilitated the process of making sense of the clinicians' work with suicidal and self-harming patients.

It is not suggested that this is the only way of approaching SH and SI and due to the complexity of these phenomena more than one approach is most likely required. The stress-diathesis theory, in which a predisposition or diathesis interacts with stressful life events and mental illness to cause suicidal behaviour (van Heeringen and Mann, 2014) is acknowledged. Mental illness and social factors are thought of in this study with regards to the impact on the patients and the way these may be seen to be associated with the presentation. The stress-vulnerability model of mental disorders (Harris, 2010, p.64) distinguishes

*'between stressful experiences, such as life events and a person's ongoing characteristics which may render them vulnerable to such stress'.*

This model implies that mental disorders are more likely to occur when these factors interact with each other rather than when stress occurs alone and unlikely to occur if the vulnerability occurs in the absence of stress (Harris, 2010). In other words, Harris (2010) highlights the interplay between the patient's outer and inner world.

## **8.2. Summary of Findings**

Four key findings will be discussed in this chapter. These include (1) the commonalities that emerged in the comparison between presentations with SH and those with SI, (2) the process by which aftercare plans are devised and the incongruence sometimes emerging between the content of the psychosocial

assessments and the treatments offered, (3) clinicians' emotional responses and attitudes towards patients, and finally, (4) the controversial theme of involving patients' carers in the psychosocial assessment. The emerging findings will be then discussed in the context of the theoretical concepts used in this study and compared to other research findings.

### **i) Commonalities between Episodes of Self-harm & Suicidal Ideation**

As discussed in chapter 4 and 5, despite some differences in the way psychosocial assessments were conducted and recorded, the model of psychosocial assessment was very similar for both sets of presentations. Similar experiences emerged in the psychosocial assessments for both sets of presentations with regards to the following parameters: relational difficulties with partners/spouses, experiences of loss or trauma in childhood and/or adulthood, health (physical and mental), environmental stressors (employment, finances and accommodation).

The psychosocial assessments showed that most patients were not in a relationship and disrupted relationships with partners or spouses were found to be the most frequent life stressor in both groups (Haw and Hawton, 2008; Liu and Miller, 2014) and therefore, some SH and suicidal states appeared to have an interpersonal context. Experiences of abuse or loss in childhood and adulthood, and an irreversible loss of a relationship with partner or spouse (through death or separation) were found to be key narratives in the psychosocial assessments for both groups of presentations. Some of those experiences could have led to trauma, for instance being raped by a fellow student. The meaning to the patient and the way that event had been processed were not always recorded in the psychosocial assessments. Therefore, it was occasionally difficult to make inferences about the impact of an event to a patient and its potential relationship with the presentation.

Childhood abuse and adverse life events have been established as risk factors for SH and SI (Bebbington et al., 2009; Kaess et al., 2013, Klonsky et al., 2008, Maniglio, 2011; Miller et al., 2013). Various theories may help with making sense of that. SH has been described as an enactment of un-integrated feelings from earlier experiences and trauma, and cutting is both seen as a defence against thinking about the past and an evocation of an earlier violation in another form

(Garder, 2011). Childhood neglect and trauma leads to poor ways of mentalising one's own emotional states (Fonagy and Target, 1997) and suicidal states and SH can be seen as a way of regulating one's emotional states (Yates, 2008). The loss of a relationship, which was a consistent finding in the psychosocial assessments and the lack of relatedness to a mentalising other (Allen, 2011) cause intense emotions of hurt, damage and incompleteness, which may be communicated through SH and SI (Orbach, 2011).

In line with the above findings, it emerged that the themes derived from the OMMP (Orbach et al., 2003a) are applicable to SH and SI. The main noticeable differences observed between the two groups were in the themes of emptiness and narcissistic wound. In relation to emptiness, those were more prevalent in the assessments of patients presenting with SI than SH. As for experiencing a sense of woundedness or a sense of catastrophic abandonment, that was more common in the presentations with episodes of SH. This could be understood in the context of unbearably painful emotional states associated with feeling abandoned, alone, alienated and disconnected from others (Bateman and Fonagy, 2006). Interestingly, the theme of wishing support and relatedness was the most prevalent theme in both sets of presentations. This may relate to the idea that SH is an expression of hope in an environment that can respond to this communication, acting as a call for others to see, hear and respond to (Motz, 2010). States of disintegration have been associated with SH and SI (Maltzberger, 2004; Motz, 2010). Both sets of presentations either through profound emptiness (SI cluster) or narcissistic woundedness (SH cluster) conveyed a sense of a disintegrated self and a disconnection from others, which as shown by the theme of support and relatedness there was perhaps a wish to repair or reverse.

Stressors related to accommodation and finances (Coope et al., 2014; Newman & Bland, 2007) were similarly reported in both groups. Quantitative studies have not managed to establish yet a clear and consistent causal pathway between financial and housing stressors and the development of SI and SH. Whilst this is still unknown, the records of the psychosocial assessments have clearly demonstrated that patients in both groups were often distressed by these difficulties. Both clusters of presentations were nearly equivalent in terms of presence of mental

illness (apart from personality disorders which were present in the SH cluster and alcohol abuse which was more frequent in the presentations with SI). Systematic reviews have reported high prevalence of mental illness in SH and suicide (Hawton et al., 2013a; Hawton et al., 2013b; Singhal et al., 2014). Some assessments recorded the distress the patients were experiencing as a result of the psychiatric symptoms (for instance, hallucinations) and psychiatrists tended to make sense of the presentations as related to the underlying mental illness.

In summary, the psychosocial assessments were found mostly to be conducted in line with the NICE guidelines (2004) for SH integrating biological, psychological, social/ environmental parameters in each presentation. Patients presenting with SI were assessed in the same way as those presenting with SH. The psychosocial assessments of both groups of patients recorded similar biopsychosocial stressors and it became clear that clinicians made some attempts to engage with the numerous emotional and social/ environmental difficulties the patients faced. The latter has been found to be important to the patients (Hunter et al., 2013). The similarities between SH and SI presentations are consistent with a study using the integrated motivational-volitional model (O'Connor, 2011) to investigate factors associated with adults having thoughts of SH (ideators) versus those associated with SH enactment (enactors) (Kirtley et al., 2012). They concluded that there were no significant differences between people who self-harmed and those who had ideations. Further research would seem very important in making sense of the factors related to the transition from ideation to SH action.

The group of patients who repeatedly presented (up to six presentations over 8 months) in A&E with SH or SI, and alcohol intoxication appeared to have received short psychosocial assessments which did not usually record the biopsychosocial parameters relating to the presentation or some of those were exceptionally briefly noted. This finding was consistent in both sets of presentations. This can be thought of from different viewpoints. Those patients appeared to have been well known to the clinicians; hence, clinicians might have not considered that a full assessment was required. It is possible that the clinicians conducted a full assessment and only a short summary was recorded. Some of those patients appeared less willing to remain in A&E in order to be assessed. Finally, this finding may be an indication of



difficulties emerging in the relational aspect of the psychosocial assessments and the alliance between patients and clinicians during assessments of SH or suicidality in conjunction with alcohol misuse. Alcohol abuse can be used as a way of relieving one's distress but, also impacts on other factors, affecting suicidality such as disinhibition, impulsiveness and impaired judgment (Pompili et al., 2010). SH has also been associated with alcohol consumption (Holdsworth et al., 2010). Systematic reviews identified negative attitudes towards people who abuse alcohol and levels of stress in clinicians working with this population with the exception of clinicians working in specialist addiction services (van Boekel et al., 2013; van Boekel et al., 2014). Less caring attitudes towards patients who abuse alcohol emerged in the focus group. However, some studies have found that mental health clinicians hold positive attitudes towards alcohol abuse (Pinikahana et al., 2002; Wheeler et al., 2014).

## **ii) Aftercare Planning: content & decision making process**

An important function of the psychosocial assessment undertaken in A&E is the aftercare plan offered to the patients. The key findings were the multi-modal care plans for both SH and SI, and the factors that affect clinicians' decision making in the aftercare planning process.

Most aftercare plans consisted of various elements/ interventions and not a single outcome and it was demonstrated that in daily practice the treatment options for both presentations are very similar. This finding from the qualitative analysis of the psychosocial assessments is consistent with the findings of the focus groups. Whereas the focus groups discussed the treatment of the mental illnesses associated with SH or SI, at the same time they maintained focused on addressing the relational difficulties, mental health difficulties as well as patients' financial and accommodation difficulties. In other words, a systemic and multi-modal approach to aftercare planning was adopted which could be viewed as an indication that there has been some agreement about the primary task (Lawrence, 2000) despite the differences in the Team with regards to discipline, education, and status. The multi-modal aftercare planning and the idea of embracing the person as a whole may also reflect that the multi-disciplinary team perhaps through exchanging skills and ideas

has developed an understanding of the complexity and breadth of SH and SI (Colombo, 1997; Vetere, 2007).

Considering the findings of chapter 4 with regards to stressful life events/ losses, there was a sense that there was a 'mismatch' between patients' stories and discourses, (as recorded by clinicians) and the aftercare plans in that referrals or recommendations to GPs for psychological therapies were rare. The consultation with the service-users revealed that psychological treatments and treatments that address the emotional experiences/ difficulties should be part of every aftercare plan and as a matter of fact, the majority of the service-users thought that their benefits outweighed those of pharmacotherapy.

The narratives of the clinicians in the focus groups shed some light into how aftercare plans are formulated which was considered to be an important finding. Symptoms or diagnosis, risks and protective factors, carers' needs but more importantly availability of resources and treatment criteria were found to be guiding the process of devising an aftercare plan. The parameter that was found to be essential for every aftercare plan was to offer treatments and services that could be realistically delivered considering lack of resources. This may be one explanation for the incongruence between patients' stories recorded in the psychosocial assessments and treatments offered if clinicians considered psychological therapies important but there was limited access. An example of this was discussed in the second focus group with regards to a patient presenting with unresolved loss and trauma related to the death of his mother but who would need to engage in treatment for his alcohol misuse before being able to access counselling/ psychological therapies. Thus, the clinician could not incorporate a referral for psychological therapies in the aftercare plan. The limited offer of psychological therapies could also be influenced by individual clinicians' ideologies or organisational defences against anxiety which aim to protect the clinicians from the anxiety and pain related to their task.

The patients' wishes and agreement with the aftercare plan also emerged as a factor that guides clinicians' thinking in the focus groups. This was in contradiction with the analysis of the psychosocial assessments, which revealed that the patients' agreement with the aftercare plan was rarely recorded. This may be attributed to

various factors. It may be that clinicians' do not routinely record that the patient is in agreement with the aftercare plan but only record disagreements when those arise. Alternatively, this may be understood as a reflective process. Schon (1983) proposes the concepts of reflection-in-action, and reflection-on-action. Reflection-in-action involves looking at our experiences, connecting with our feelings, and attending to our theories in use and entails building new understandings to inform our actions in the situation that is unfolding (Schon, 1983). Reflection-on-action follows and enables us to spend time exploring why we acted as we did, what was happening in a group and so on (Schon, 1983). Participants in this study were reflecting on their work as opposed to reflecting while working and therefore, this may partially explain the difference emerging between the records of psychosocial assessments and the discussions in the focus groups with regards to patients' agreement with the aftercare plan. A qualitative study exploring patients' experiences of psychosocial assessments found that patients were often unclear about the timing and procedure for follow-up care, and that several participants were disappointed with the outcome of the assessment as they were either referred back to their GP or to the team already involved with them which felt to be unhelpful (Hunter et al., 2013). Therefore, communicating and discussing the aftercare plan is an important parameter and function of the psychosocial assessment.

There was some difference between doctors and nurses in the focus groups with regards to aftercare planning, such as whether to admit a patient or not, and a lot has been written about the relationship between these two disciplines. There were differences between the nurses themselves which may imply that other factors apart from professional disciplines are implicated in this. Bion (1961) suggests that schisms are created among members which are determined by the avoidance of painful experiences related to the primary task. When aspects of reality central to the purpose of the group become emotionally demanding, they may be avoided by a schism in the group into fractions that represent the opposing aspects of the conflict (Hinshelwood, 2008). For example, there was a clear sense that the population that presents with SH and alcohol dependence challenges the team particularly in the process of devising an aftercare plan due to limitations in various services and patients' difficulties.

That seems to have led to two different cultures and two care models in opposite directions within the group. One culture was to decide to not attempt to work collaboratively with the GP in identifying aftercare services keeping in mind the belief that people who misuse alcohol have a very chaotic life style and not engage with their GPs but to offer information about alcohol services. The opposing culture was to simply write to the GP thinking the GP both knows the patient and has access to resources. The reality may well lie in between those opposing ways of thinking about an aftercare plan and in some regards these different ways of thinking complement each other.

In summary, the psychosocial assessments revealed that clinicians approach aftercare planning for SH and SI in similar ways and that aftercare plans usually consist of various elements in an attempt to address the patients' mental health and psychosocial needs. The focus groups identified some parameters that guide clinicians' thinking in the aftercare planning which focus on patients' needs and take into consideration issues related to resources.

### **iii) Clinicians' Emotional Responses & Attitudes towards Patients**

The main findings are as follows: clinicians' emotional responses to patients with SH and SI varied and to some extent depended on the despair of the patient and shared characteristics between patients and clinicians (such as ethnicity); lack of space to think of the emotional impact of this work on the clinicians; the therapeutic qualities of the psychosocial assessment were discussed; attitudes were found to be dimensional and not binary.

Clinicians were found to have a variety of emotional responses to the patients' presenting in A&E from feeling cut-off from the patient to feel empathy. The first focus group was hesitant to think of how they would relate to the patient of the vignette and as a matter of fact it was indicated that it was a hard question to answer. There was a narrative about relating to the patient discussed in an emotionally blank way which would be guided by rational thinking and information gathering. As well as an attack on an individual's body, SH can also attack the minds of others (Campbell and Hale, 1991) such as clinicians' in A&E who may try to prevent or stop it, due to the fear of suicide. Repeated experiences of trauma and

mental pain were found in the analysis of the psychosocial assessments. In working with patients who SH or are suicidal, intense emotions of hostility, loneliness, hopelessness may arise which can be difficult for the clinicians to manage. Therefore, in the face of intense and unbearable feelings experienced in the countertransference throughout their working day as their primary task is to assess people presenting in A&E with SH and SI, it may be that the clinicians attempted to avoid making any emotional connection with the patients and defensively focused on 'rational thinking' and symptoms at the expense of the patient's emotional turmoil. Redley (2010) carried out research with clinicians in a specialist ward for people needing an admission following an A&E presentation with SH. A participant in Redley's study (2010, p.480) stated:

*'I think you have to be detached. I mean you can't get emotionally involved in people's lives'.*

Steiner (1993) named the protective structures created by the individual who is dominated by fear of reality as 'psychic retreats'. This idea is helpful in making some sense of clinicians' attempts to escape from having to think about their interactions with such troubled and distressed patients by becoming emotionally detached from them. However, the data from the focus group here suggest this response was more on a collective than an individual basis.

On that occasion therefore, the possible denial of aspects of clinicians' emotional-self seemed to be a collective social defence (Menzies-Lyth, 1960) by which clinicians' own anxieties and possibly other unbearable feelings were kept at bay. Hinshelwood and Skogstad (2000) argue that in mental health hospitals clinicians' fears of being overtaken by madness and violence can be kept safely controlled by a rigid division in which madness resides with patients only and sanity with the clinicians only. This may well be partly applicable to the process of the focus group in which clinicians initially made no emotional connection with the patient of the vignette. When clinicians, working with SH and suicidality, remain immune from the overwhelming feelings experienced, their relationship with the suicidal patient is attenuated, and this can lead patients to experience suicide-inviting affects of loneliness and abandonment (Maltsberger and Buie, 1974). Therefore, clinicians' capacity to mentalise is crucial in working with SH and suicidality as the patient

needs to be helped to make the important distinction between thinking about SH or suicide and acting on impulses (Holmes, 2011).

Interestingly as the discussions in the focus groups progressed, clinicians connected with the patients' and their own emotional worlds and as a result, their countertransference experiences. Compassion, empathy, uncomfortable feelings and ambivalence towards patients emerged. Feeling torn between the duty of care towards the patient, and the duty to the society became a highly charged theme from an emotional viewpoint specifically in relation to protecting patients' children as if adult mental health and protection of children were two opposing forces in conflict that could not be integrated. A link between parental mental illness and a range of adverse outcomes for their children is well established (RCP, 2002). Parental SH is considered to be a significant risk factor for children's wellbeing and the role of adult mental health services in safeguarding children has been highlighted (RCP, 2002).

The group agonised over the idea of a child protection referral for patients presenting in A&E. There was a clear sense that the extensive training, work discussion and policies within the Trust led them to rigidly/ ritualistically consider a child protection referral for the patient of the vignette and patients in real life. Initially there was an emphasis on the need for child protection referrals; a need in the group's mind, highlighted in 'inquiries' which seemed to have given rise to anxieties for the experienced clinicians in the group. Rustin (2005) argues that child protection evokes infantile anxieties in staff and on this occasion there was a sense that the uncertainty regarding the child's wellbeing which is a very difficult position to hold and the group's dependence to the authority of the Trust was perhaps leading to rules and policies being implemented in a mindless way. Child protection was the most prominent theme activating the team's dependency needs.

As discussed in chapter 2, in Bion's (1961) theory of the basic assumption group, individuals are endowed with a specific valency to form a sense of social entity with each other, one of them being basic assumption-dependency. On this occasion, the group-team appeared to be dependent on 'policies' and 'procedures' with regards to making 'right' decisions about child protection as well as to the impersonal authority of the 'Trust'. A shift occurred in that there was some recognition that patients can be alienated if clinicians' capacity to listen to the patient

at an emotional level is interrupted by clinicians' anxieties and un-thoughtful responses. In the process of the focus group there was a realisation that training, staff discussions and policies have not been sufficient in helping them to develop emotional competence in balancing the needs/wellbeing of their patients and the needs/wellbeing of the patients' children. Clinicians working in community mental health teams have been found to use a combination of formal and intuitive knowledge in decision making in child protection with clinicians' feelings being implicated in all aspects of decision making (Rouf et al., 2011). Interestingly, a study found that inter-agency joint protocols for safeguarding children in social care and adult mental-health agencies increased awareness of the risk factors for children but some practitioners' felt their practice was shaped more by interpersonal contact with practitioners from other agencies rather than protocols (Webber et al., 2013).

Patients' experiences of desperation seemed to have a central role in the relationship between patient and clinician and those patients who conveyed their despair appeared to elicit kind and caring responses from the clinicians. Patients who seemed to share common characteristics with clinicians such as culture and ethnicity seemed to arouse stronger and more sympathetic emotional responses in the clinicians compared to the other patients. Suicidal threats by patients may create anxieties in mental health professionals and imply professional failure, and as a result partially or fully arrest clinicians' capacity to adequately contemplate the mental state of patients (Bateman and Fonagy, 2006). Colluding with patients wishes to be contained in an inpatient ward as a way of managing their own anxieties about keeping patients safe and surviving as professionals was acknowledged in the focus groups. Although it was underlined that clinicians might feel that they were held hostages by patients' suicidal threats, there was only a disclosure of feeling 'uncomfortable' about that and no other emotional content was assigned to it.

Difference in opinion emerged with regards to having a space to think of the complexity of the work in emotional terms. With the exception of one member who perhaps as a manager felt compelled to defend the efficiency of their structures and processes, there was a sense that rarely do they think of the emotional impact of their work which perhaps may explain the initial reluctance to discuss about it in the focus group. Being attuned to the experiences of a suicidal or self-harming patient,

considering that these experiences may be painful enough to activate clinicians' countertransference withdrawal or to cause clinicians to respond in a hostile manner, is a major challenge for clinicians engaged in this work. As a result, in order for mental health professionals to be able to manage responses to intense distress and violence that SH can create on the body and in the minds of those who encounter it (Motz, 2009b), a reflective space in supervision or discussion with colleagues is essential. It was perhaps this realisation that led a member of the focus group to express the need to revisit the Team's supervision arrangements.

In these short and one-off encounters in A&E, the therapeutic aspect of the psychosocial assessment and the concept of therapeutic alliance were found to be important. Validation of patients' experiences was described as a component of the therapeutic relationship between patients and clinicians in the focus groups. The importance of the therapeutic alliance in working with people who SH or are suicidal has been highlighted in the literature (Wenzel and Beck, 2008). The consultation event with the service-users also underlined the importance for patients to feel 'listened to' and 'understood' by clinicians and considered the relationship between the patient and the clinician during a psychosocial assessment of supreme importance. In keeping with this, qualitative research on service-users' experiences of psychosocial assessments found that psychosocial assessments were valued when patients felt that their needs were legitimised (Hunter et al., 2013).

Attitudes towards patients who SH or presented with SI appeared to vary ranging from caring attitudes towards patients to seeing patients as manipulative. On some occasions clinicians were found to hold both negative and positive attitudes about a patient/ group of patients. Therefore, in this study, attitudes were found to be multidimensional including various responses as opposed to be categorised in a binary way- bad and good or positive and negative. Interestingly though more often clinicians maintained a sympathetic and compassionate attitude towards the patient-person as a whole but nevertheless, expressed negativity about specific issues related to a patient. A recent systematic review concluded that attitudes of general hospital staff were largely negative towards patients who self-harmed (Saunders et al., 2012). Psychiatric staff in community and hospital settings were found to display more positive attitudes compared to general hospital clinicians in that review



(Saunders et al., 2012). However, the attitudes of staff in psychiatric liaison have not been well explored. It seems important to differentiate between A&E medical staff and psychiatric liaison staff as well as psychiatric staff in other fields, considering that the primary task of liaison teams is to engage with SH in an emergency setting.

The consultation event discussed extensively care experiences being deprived of meaning, sensitivity and being characterised by negative attitudes – feelings of being judged. Nathan (2006) suggests that patients who SH are, by definition, both perpetrator and victim and as previously discussed, clinicians may be prone to intense negative countertransference reactions if SH is viewed as the perpetration of violence. Nathan (2006) adds that paradoxically, when faced with intolerable and incomprehensible acts of self-harm, clinicians can be drawn into re-enactments of abuse, for example, clinicians may find themselves taking a hostile stance towards the patients who SH, and verbally re-enacting an abusive scenario with which the patients are familiar. This may explain why service-users often experience clinicians as intrusive, rejecting or unconcerned.

Participants in this study were reflecting on their work- reflecting-on-action as opposed to reflecting while working- reflecting-in-action (Schon, 1983), and therefore, this may partly explain the findings and the presence of some positive and caring attitudes. In addition, a different study design, for instance collecting data through organisational observations may have resulted in different outcomes. Finally, although a number of dilemmas and difficulties faced in daily clinical practice were discussed, all participants appeared to be confident in their assessment skills and in their ability to deal with patients difficulties which may be implicated in the findings.

One of the most interesting aspects of thinking about this data was the consultation with the service-users and more specifically, their spontaneous attempt to mentalise why clinicians may come across as insensitive, uncaring and with poor skills to emotionally listen to the patients. Firstly, it was hypothesised that it might be challenging for doctors and nurses whose job was to protect life, to treat people who self-injured. The service-users hypothesised that some clinicians have the wish to provide good care but nevertheless lack the skills to do so, or that their thinking is being organised by the terror of a possible suicide and its impact upon their professional survival. Finally, there was a thought that clinicians may be facing

difficulties of their own and therefore, being distracted from their duty of care due to their personal difficulties.

In summary, this study has found that clinicians had various emotional responses when conducting psychosocial assessments as well as attempting at times to become emotionally disengaged from their task. Therefore, it seems that clinicians oscillate between different positions and emotional states. Similarly, the attitudes clinicians hold towards SH and SI are multi-faceted and cannot be categorised simply as negative or positive as some of the literature suggests (Saunders et al., 2012). The team did not appear to have one shared attitude towards SH and SI and difference in the narratives of the focus groups' members emerged. Clinicians recognised the therapeutic nature of the psychosocial assessments undertaken in A&E and not only focused on risks. The concept of the therapeutic alliance and threats to it, such as a referral to children's social care was discussed in a very lively way. The basic assumption-dependency (Bion, 1961) was strongly activated during that discussion and the focus group became solely and rigidly dependent on policies leaving little room for them to use their clinical judgement and discernment in a helpful way.

#### **iv) Involving Family & Carers**

The NICE guidelines (2004) recommend that people who SH should be allowed to be accompanied, if they wish, by a family member or friend during the psychosocial assessment, and the need to offer emotional support and help to family and carers is pointed out. Key themes that emerged in the study were: carers/relatives' involvement in the psychosocial assessment and whether to offer support to the carers for their own difficulties.

Relatives, carers and friends were considered to play a crucial role in the care and treatment of patients by the participants of the focus groups. Participants considered important to hear the carers' accounts of the patients' history and current difficulties. The focus group expressed an appreciation that every party needs to have their voice heard and therefore, it is essential that carers' worries are heard by the clinicians. However, dilemmas emerged in relation to how to involve carers and relatives in the psychosocial assessment, in principal due to issues of confidentiality

and consent to information sharing. There was an acknowledgment that the need to gather corroborative information should be balanced with the patient's right to privacy. The lively debate that took place in the focus group is to some extent reflected in the literature for people with other presenting difficulties. A study collecting data from three sources (policies, service-users and professionals) concluded that there is not yet consensus in the UK as to best practice when patients with psychosis refuse or give only partial consent to information-sharing with carers (Slade et al., 2007). A systematic review (Rowe, 2012) of the literature on family, carers and mental illness concluded that clear principles need to be published to guide information sharing that takes into account confidentiality, consent and the needs of the family carers.

The service-users consultation group identified two reasons why involving relatives and family carers was not desirable. The nature of relationships with family and friends could change if family members and friends felt the need to adopt the role of the 'therapist' which was considered to affect both people involved in the relationship in an unhelpful way. A strong fear was expressed that sharing information and involving family and carers in the therapeutic relationship might result in family and friends seeing the service user at his worst continually. Involving families and friends was, therefore, seen as stigmatising the service users.

On the other hand, the consultation group acknowledged that involving family members in the assessment process might be helpful considering that they could offer an insight into what might have led to SH and the meaning of it. It was shared that sometimes when patients and carers had a good relationship with each other, carers could perhaps facilitate the therapeutic process or could seek help on behalf of the patient. A thought was expressed in the consultation group that by involving family members in the psychosocial assessment, difficulties could be identified and subsequently services could be provided. Eventually, whilst undesirable consequences were expressed with regards to involving carers and family members in the psychosocial assessment, helpful aspects of family/ carers' involvement were identified. Thus, a balanced view eventually emerged as opposed to occupy one pole or the other.

The clinicians who participated in the focus group demonstrated willingness to engage in a dialogue and negotiation with the patients regarding the need to liaise

with their carers/relatives. This was only found in one psychosocial assessment in this study. Exploring the views of the carers was only found in an exceptionally small number of psychosocial assessments. It is rather difficult to make inferences regarding the discrepancies between the narratives in the focus groups and those from the routinely collected data as chance may have been implicated in that the psychosocial assessments included in the sample did not include carers' views/accounts or that those are not recorded routinely. It may also mirror the difficulties/dilemmas clinicians face in involving carers in the psychosocial assessments. Alternatively, it may also show the difficulties patients often reported in their relationships with family, partners and friends and is an indication of their isolation.

Service-users suggested that SH and suicide attempts are emotionally upsetting and traumatic for families. The emotional impact of SH has been well documented in research studies with parents of adolescents. Parents describe feeling shock, anger, disappointment, helplessness, a sense of failure, shame and guilt, anxiety and sadness (Byrne et al., 2008; Morgan et al., 2013; Oldershaw et al., 2008; Raphael et al., 2006; Rose et al., 2011). Caring for a suicidal family member has been found to be emotionally demanding (McLaughlin et al., 2014). Research specifically on parents of adult children who SH or experience SI is sparse. Raphael *et al.* (2006) included in their sample parents of young adults (18-24 years old) and found that parents had concerns regarding coping with their child on discharge from hospital and were worried about the possibility of future incidents. These anxieties were found to be exacerbated by a perceived lack of information and support from some health professionals. Lindgren *et al.* (2010) conducted a qualitative study with a small sample of mothers whose adult daughters were self-harming and had used inpatient and outpatient care as well as emergency departments in Sweden. Some mothers reported feeling invisible, not being listened to and not being involved in their daughter's care and other accounts described experiences of being comforted by the mental health professionals (Lindgren et al., 2010).

Experiencing loss and bereavement was considered to be the case each time a child or a family member had an episode of SH by the members of the service users consultation group which is consistent with research findings (Lindgren et al.,

2010). Whilst it became apparent from the contributions of the service-users that the involvement of families and carers may have a negative impact on them and their family life, the consultation group acknowledged the carers' need to be involved in the process of assessment and therapy. This was seen as an opportunity to help carers to make sense of SH/SI, and to understand how to approach this in a helpful way for the service-users. This is in keeping with the need for support and information about SH and its management found in other studies (primarily though for adolescents) (Byrne et al., 2008; Oldershaw et al., 2008; Raphael et al., 2006).

The emotional, social and physical needs of family members as carers were acknowledged by the clinicians. The interplay between the patient's difficulties and those of his/her partner were highlighted. Addressing the difficulties of carers (for instance, recurrent use of alcohol) became a contentious theme that was discussed comprehensively. Difference in opinion emerged in relation to whether and what support could be offered (for example, an information leaflet) to family members for their own difficulties considering that they were not the actual patients treated in A&E. Although this was perceived as a bureaucratic obstacle, it was considered to be a very legitimate constraining factor particularly for one member of the group. Whilst there was eventual consensus in that a leaflet with information about services could be given to a relative; the apparent consensus might have been an outcome of a decision to conform with the majority of the group as opposed to the outcome of the discussion and shift in opinions. In other words, the dynamics among the members were considered to influence the content of the data gathered. This theme exemplified how participants can respond as individuals with unique beliefs and preferences as well as representing organisational positions but also revealed differences in how each discipline approaches a clinical matter.

The themes of consent and offering help to carers demonstrated differences in how individual clinicians and each discipline understand aspects of their primary task (Lawrence, 2000). Thus, it exemplified lack of clarity about the primary task, which can often be present in multi-disciplinary teams, and the need for on-going discussion and negotiation of the primary task of the organisation (Obholzer, 1994). Interestingly differences also emerged between clinicians of the same discipline with regards to the primary task (particularly in the theme of consent) which may suggest

that factors other than different trainings and professional values contribute to difficulty in developing a coherent and shared purpose in multi-disciplinary teams. Lack of clearly defined and agreed primary task has been suggested to relate to the tendency to basic assumption mentality since there are no obvious criteria for members to tell whether a particular topic or activity is relevant to the task or not (Stokes, 1994).

### **8.3. Study Limitations**

There was an effort to include psychosocial assessments of patients from different gender, age, ethnicity, and socio-economical status within this population in order for the spectrum of individual experiences to be explored. Both SH and SI are heterogeneous phenomena and therefore, selection bias may have been introduced. The number of clinicians involved in these assessments was small and from one team, which may have implications with regards to how representative the findings are.

Credibility refers to the accuracy and sincerity of the records/ notes used in the sample (Silverman, 2011). These assessments are constructs influenced by a wide variety of factors related to the patients' experiences but also shaped by the clinicians' training/ orientation as well as other constructs such as the NICE guidelines (2004) and the way SH is perceived in the current literature/ scientific world. Hence, this data set was not treated as a source of establishing the 'true' facts of cases but as a source of exploring how patients' stories are represented and constructed in this specific context.

The sample size of the focus groups was small and was drawn from a single hospital. However, this was appropriate considering the aim to study team and organisational contributions in understanding the process of assessment and treatment. The small sample limits the study's transferability and findings are therefore in the domain of generation of themes and ideas. On the other hand, this sample offered a very in-depth account that most likely would not be able to obtain in a larger group as the members who participated were highly involved in the

discussion and mostly very experienced. A longer or an additional focus group might yield greater insight into the decision-making and attitudes/ emotional responses of clinicians. This would have resulted in greater burden for the participants, and therefore perhaps decreased likelihood of clinicians agreeing to participate.

The first focus group initially considered the vignette to be atypical as in their opinion not many middle-aged Afro-Caribbean women presented in A&E with SH as well as that not many self-harmers would be likely to present '*...in the morning*'. The coalescence of the group's comments at that stage could be seen as questioning the believability of the vignette from the outset. This raised a question as to whether the group might be mobilising to undermine the process using the amassed 'reality' of its considerable front-line experience to challenge the legitimacy of a case vignette presented to them as part of research. Soon afterwards the group was able to engage in the process using their curiosity and their ability to think of alternative explanations. A member later on shifted her view and referred to the vignette as the '*bread and butter*' of their work, and another one noted that she would not be surprised with a presentation like this.

The use of focus groups was considered to best address the aims of this study. Collecting this type of data as opposed to individual interviews with clinicians added to the complexity of data analysis. In chapter 6, it has been shown how the dynamics among the participants influenced the data collected. Whilst, this can be perceived as a limitation of focus group research as the information presented by participants may not be 'objectively true', Rapley (2007) suggests that people make decisions and choices on the basis of on-going interaction and information exchanging with others. The analysis of the interactional data in focus groups has been a rather neglected area compared to the analysis of the content of the discussions in focus groups. Whilst there have been recent attempts in considering this type of data- interactions in focus groups, this is definitely a research method that requires further attention.

This is a mixed methods study due to the fact that different qualitative methods were employed using three sources of data collection, namely records of psychosocial assessments, focus groups and consultation with service-users. In addition, it emerged from a quantitative study. Using different methods and data

sources offered the opportunity for developing a narrative about the psychosocial assessments carried out in A&E for adults presenting with SH or SI from different perspectives. Each type of data complemented the other in an attempt to explore the complex phenomena of SH and SI, and to reach a richer understanding. This was considered to be the main strength of this study. Hammersley and Atkinson (1983, pp.12-13) suggest that

*'one should not adopt a naively optimistic view that the aggregation of data from different sources will unproblematically add up to produce a more complete picture'.*

During the data analysis there were instances in which different perspectives and narratives emerged from the different data sets. Considering that mixed methods were not used in this study in an attempt to produce a 'unitary or rounded reality' (Brannen, 2005) or a 'context- free truth' (Silverman, 2011), those differences were explored and thought of in the different contexts which they arise.

#### **8.4 Suggestions for Future Research & Practice**

In light of the evidence for treating SH, the therapeutic value and the importance of the psychosocial assessment in patients' future engagement with services, it may be helpful to develop a therapeutic assessment tool for conducting psychosocial assessments similar to the Therapeutic Assessment (Ougrin et al., 2011) developed for adolescents with SH episodes. This has been found to be associated with significant improvement in engagement with services further to the SH episode (Ougrin et al., 2011). However, it is acknowledged that it has not been associated with a lower frequency of A&E SH presentations (Ougrin et al., 2013). Needless to note that there is still limited understanding into the transition from having ideas to SH to actually act up on those and recent research suggests that SH and SI are partly influenced by the same biological mechanisms (Maciejewski et al., 2014). Further research in exploring how the transition from SI to SH is made would be beneficial in relation to treatment and prevention of SH and suicides. Considering the strong messages the service-users gave during the consultation event, as well as other research findings, it is clear that former experiences of psychosocial



assessments being carried out in A&E, influence future A&E attendance. In view of the high prevalence of repeat SH, further qualitative research may be helpful in exploring in depth how patients make the decision to re-present or not to A&E. As this is one of the very few studies that described psychiatric liaison clinicians' attitudes, further research may be helpful to explore this. From a methodological point of view, the analysis of the interactional data in focus groups is a qualitative method that requires further research and evaluation.

The current NICE guidelines (2004; 2011) offer recommendations for assessing SH episodes; however, this study has shown that patients with SI are treated very similarly using the same assessment framework. Hence, it may be that separate guidelines are not in need for the management of people presenting in A&E with SI. The clinical task in liaison psychiatry in A&E involves making rapid decisions about SH and SI both of which are complex and to some extent heterogeneous phenomena involving painful stories and serious risks. Thus, the emotional impact of this work on the clinicians should not be underestimated. Clinicians working in A&E are confronted with logistic difficulties related to waiting times, lack of space and resources, and dilemmas with regards to local processes. Many studies highlight the importance of offering training to clinicians working in this field in order for the attitudes towards patients to be improved (Saunders et al., 2011). However, it seems that providing support and a space for clinicians to be able to think of their task and their responses is essential as teams who provide emotional containment need to feel contained and supported in order to provide care in the challenging and often unpredictable environment of A&E (Grocutt, 2009). Supervision and reflective multi-disciplinary discussions would appear important. Both clinicians and service-users agreed that an important function of the psychosocial assessment is the aftercare planning. Hence, it is thought that thoroughly exploring with the patients their own hopes from attending A&E as well as clearly explaining the aftercare plan offered would be helpful. Finally, considering that a high number of patients in A&E seems to be in crisis and in need of intense support but often with no support networks around them, a service providing outpatient daily care may be proven to be beneficial.

### **8.5. Suggestions for Social Work Practice**

Social workers come into contact with people who SH or experience SI in a numbers of practice settings, namely multidisciplinary mental health teams, services for older people, drug and alcohol services. Social workers also encounter young people who SH and are known to children's social care or children/ young people whose parents SH or are suicidal. A significant relationship has been identified between social work contact in the last year and lifetime suicide attempt (Slater et al., 2015). In light of this, it would seem important for social workers to be able to assess people who SH or are suicidal integrating biological, psychological and social/ environmental parameters, and to work with this population. Social work degrees are reported to offer little education in suicide prevention and intervention (Osteen et al., 2014; Ruth et al., 2012; Scott, 2015) and social workers' skills to work with suicidal people have been found to be limited (Osteen et al., 2014). As a result, it may be important that social work students are taught about SH/suicidal behaviour on their qualifying courses and that further training opportunities are offered post-qualification concerning these topics.

Clinicians participating in this study referred to the emotional impact of working with SH and suicidality. Similarly, social workers appear to discuss practice situations involving people at risk of SH or suicide describing this population as some of their most difficult cases taken to supervision (Pack, 2011). Furthermore, social workers report that they feel unprepared to work effectively with this population (Osteen et al., 2014). As a result, alongside access to training, reflective supervision may be important. The interpersonal context of SH and suicidality has transpired in this study in keeping with other studies which may highlight the need for relationship-based social work (Ruch, 2012). Child abuse has been associated with SH either during adolescence or adulthood, and was a theme in this study. The pathways for this association are complex (Lang and Sharma-Patel, 2011) and referring children/adults abused for specialist/ trauma interventions may be an important prevention strategy that social workers could employ. Finally, social workers often offer outreach services (such as home visits) and very often involve people's families. Service-users participating in this study highlighted the need for involving families in a meaningful way in patients' lives which is an area that social workers

may be well positioned to address considering the systemic approaches have been an important feature in social work practice (Wilson et al., 2008).

## **8.6. Conclusion**

The above discursive discussion presented the main findings from the three data sets in the context of theoretical concepts drawn primarily from psychodynamic theories whilst some attention was paid to social factors and illness. Personality and individual differences, cognitive factors, social aspects, and negative life events are key contributors to suicidal behaviour (O'Connor and Nock, 2014); the choice of psychodynamic concepts was influenced by the study's approach to psychosocial assessment as an interactional therapeutic encounter between patient and clinician. Findings from all three datasets reveal that psychosocial assessment in A&E for both SH and SI is a complex multi-dimensional task. The participants of the focus groups became increasingly in touch with that complexity in the process of the discussions and reflected upon their dilemmas, struggles and to some extent, the emotional impact of the work on them. The records of the psychosocial assessments revealed that patients often faced emotional distress, had troublesome relationships with their partners or felt abandoned by them and sometimes faced social stressors and mental/physical illness. The discussions and reflections of focus groups' participants highlighted the importance of the counter-transference and defences from anxieties related to the nature of this work. Therefore, the mixed method approach offered the opportunity to explore the interplay of various factors and dynamics that influence the clinicians' assessments and aftercare planning. This in conjunction with some participants' comments about the lack of having a space to reflect upon their work could perhaps be used to generate more meaningful care for the patients attending A&E and more helpful work- environments for clinicians.

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## Appendix A

### Appendix A. 1. Patients Experiences of Psychosocial Assessments

Author	Context	Findings
<b>Hengeveld et al., 1988</b>	Netherlands. 120 patients who had received emergency psychiatric assessment following suicide attempt. Interviews using open and closed-ended questions. Quantitative analysis; unclear how narrative in open-ended questions was analysed.	1/3 respondents had previous experience of suicide attempt and felt psychiatrists did not show interest in their previous attempts. 1/4-1/5 of respondents were negative or dissatisfied with the care they received.
<b>Horrocks et al., 2005</b>	UK. Qualitative interviews with 45 patients about their experiences of hospital care following self-harm. Method of analysis: not clear	Experiences of A & E staff: waiting times, lack of privacy, feelings of isolations, feeling invisible, lack of communication about treatment, being processed, wanting understanding, negative attitudes, but some positive experiences of communication. Psychosocial assessment: being processed, lack of empathy, acceptance and understanding, lack of experience, difficulty talking. Aftercare: disorientation, abandonment, delays, using contact numbers.
<b>NICE, 2004</b>	UK. 2 Focus groups with service users (10 in total) and one semi-structure interview with a service user. Experiences of care received 48 hours post self-harm. Method of analysis: not clear	Predominantly negative experiences due to staff's attitudes. They felt not listened; nevertheless, this trait referred to A & E medical doctors and nurses. They would like to be consulted re treatments offered. Concerns were raised by some participants about the aftercare plans and how the decision for treatment allocation was made.
<b>Palmer et al., 2006, 2007</b>	UK. Audit using a survey 206 service users respondents in the 1 <sup>st</sup> phase and 87 in the 2 <sup>nd</sup> phase about A & E experiences following self-harm	48% (1 <sup>st</sup> phase) and 60% (2 <sup>nd</sup> phase) rated staff a excellent or good. 52% at baseline and 72% in the 2 <sup>nd</sup> phase felt that people with self-harm injuries were treated with the same respect as patients with other injuries. 75% respondents felt they were not offered appropriate after care.

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## Appendix A. 1. Patients Experiences of Psychosocial Assessments

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Author	Context	Findings
Hunter et al., 2013	UK. Interviews with 13 patients. Method of analysis: IPA	Positive and negative experiences. Participants value psychosocial assessments that address both psychological and social needs.

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## **Appendix A.2. Frequently Used Scales to Measure Attitudes \***

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### **Attitudes To Deliberate Self-harm Questionnaire (McAllister et al., 2002)**

33 items on a four point Likert scale. Low reliability; further psychometric properties have not been tested. Developed in Australia.

### **Suicide Opinion Questionnaire (Domino, 1982)**

100 items (attitudes and factual information) and 7 additional items. Likert type response scale of strongly agree, agree, undecided, disagree, and strongly disagree. It has been used extensively; however, its psychometric properties have been found to be weak (Anderson et al., 2008; Lester, 2009; Rogers & DeShon, 1992). Developed in the USA.

### **Understanding of Suicide Attempt Patient Scale (Samuelsson et al., 1997a; 1997b)**

11-item scale. Each statement was scored on a five-point Likert scale. It is intended to measure understanding and willingness to care for patients who have attempted suicide. The scale has demonstrated satisfactory internal consistency and good reliability (Mackay & Barrowlough, 2005; Samuelsson et al., 1997a; 1997b). It was developed in Finland.

### **Self-harm Antipathy Scale (Patterson et al., 2007)**

30 statements about people who self-harm and invites the participant to indicate agreement or disagreement on a 7-point Likert scale. Preliminary evidence suggests acceptable validity and good internal consistency. Developed in the UK.

*Other measures less frequently used:*

***Suicide Attitude Questionnaire (Diekstra et al., 1989)***

***Attitudes towards Suicide Questionnaire (ATTs) (Salander et al., 2003)***

***Suicide Behavior Attitude Questionnaire (Botega et al., 2005)***

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\* See References for details

### Appendix A. 3. Attitudes of specialist psychiatric staff: Included Studies

Author	Context	Findings
<b>Gibb et al., 2010</b>	New Zealand. Attitudes to self-harm. 195 health care professionals in general and psychiatric hospital including A & E. 18 item questionnaire regarding attitudes, Maslach burnout inventory.	Mixture of positive and negative attitudes. Staff thought their contact was helpful to self-harm patients and were optimistic about outcomes. Did not feel confident working with self-harm and felt that their training was not adequate. Attitudes were not associated with age, gender, experience but high levels of burnout was associated with more negative attitudes. Emergency and psychiatric staff were less likely to find communicating with patients who self-harm difficult. Emergency staff found repeated self-harm particularly difficult to work with.
<b>Platt &amp; Salter, 1987</b>	Scotland. Attitudes towards parasuicide. 74 medical nurses, doctors, specialist psychiatric staff from two hospitals and 100 participants- general population. Vignettes and Repertory Grid instrument.	Clinicians view patients more positive and sympathetically than the public. No difference in attitudes between specialist and general hospital setting. Psychiatric staff were more likely to view parasuicides rewarding and challenging to care for compared to medical doctors.
<b>Redley (2010)</b>	UK. Qualitative-Observational	Clinicians avoided exploring the patients' reason for OD as a refuge from painful emotional experiences.
<b>Royal College of Psychiatrists, 2010</b>	UK. Survey. Attitudes to self-harm. 52 Psychiatrists working in Liaison Teams among other disciplines. Attitudinal questions regarding psychosocial assessments, causes of self-harm, role of psychiatrists, discharge, psychological therapies, service provision. Questionnaire and qualitative data. Not specified how qualitative data were analysed.	Very difficult to record findings as the report does not specify the responses of psychiatrists working in Liaison. Psychiatrists in Liaison had training for psychosocial assessments, discharge often decided by junior doctors, admission to inpatient difficult as there is a lack of beds, 50% respondents reported that sufficient availability of psychological therapies.
<b>Samuelsson et al., 1997a</b>	Sweden. Nurses' attitudes to attempted suicide. 197 nurses in	Reliability of the scale was satisfactory. Women tended to be

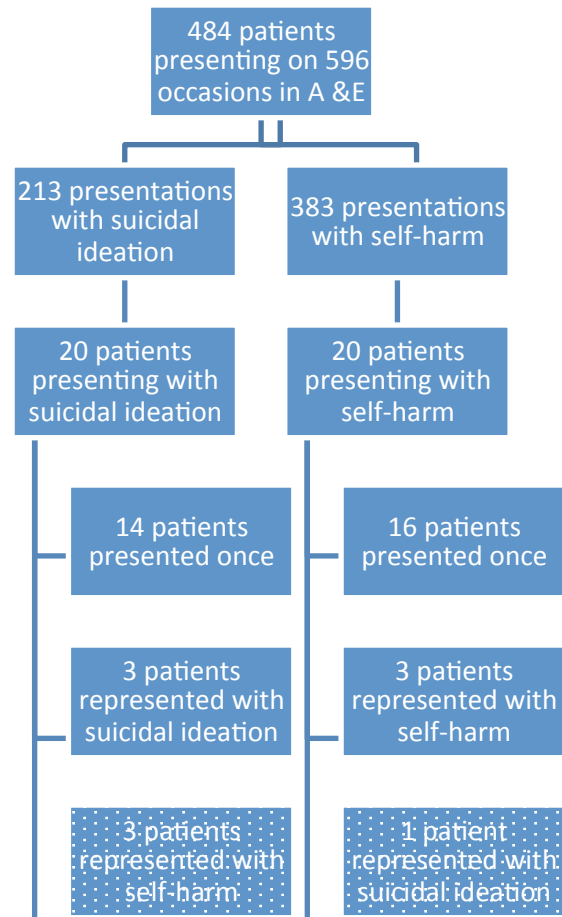
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	psychiatric hospital services including Psychiatric Emergency Department. Understanding Suicidal Patient Questionnaire and 3 vignettes accompanied by 3 questions.	more sympathetic than men and older personnel more favourably disposed than the younger. Emergency personnel had significantly more positive attitudes towards suicide compared to personnel in intermediate and long term care.
<b>Samuelsson et al., 1997b</b>	Sweden. Attitudes towards attempted suicide patients. 160 general and psychiatric nurses. Understanding Suicidal Patient Scale accompanied by 3 vignettes.	Nurses in specialist psychiatric services were more understanding and willing to nurse patients who attempted suicide than general nurses. Older personnel more positive. General nurses indicated higher need for training.
<b>Suokas et al., 2008</b>	Finland. Attitudes of accident and emergency staff towards suicide attempts. 151 clinicians of a General and a Psychiatric hospital. Understanding Suicidal Patients Questionnaire.	Overall, staff viewed patients who attempted suicide positively and sympathetically. However, those in General hospital expressed more negative attitudes compared to those in the Psychiatric hospital. No association between staff members' distress and attitudes towards suicide attempters.
<b>Suokas et al., 2009</b>	Finland. Attitudes of accident and emergency department staff towards suicide. 100 respondents. Understanding Suicidal Patient Questionnaire.	The level of positive attitudes toward in the start of the study was good. The establishment of a psychiatric consultation service did not alter attitudes.

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## Appendix B

### Flowchart of sample selection



## Appendix C

### C.1. Sample of coding under the theme: 'Interpersonal Relatedness-clinician's understanding of Suicidal Ideation'

<Internals\\A & E assessments\\Suicidal ideation\\23.1\\23.1> -

He was suicidal and preoccupied with what the female resident had said- He feels angry and frustrated with the female resident

<Internals\\A & E assessments\\Suicidal ideation\\236\\236.3> -

DSH thoughts *due* ongoing **social and** psychological issues around child care. Does not want to see her children.

<Internals\\A & E assessments\\Suicidal ideation\\312\\312> -

(*Name of patient*) reports that over the last few months she has had intrusive thoughts about ending her life. There appears to be a direct link between this and worsening situation at home as well as reporting having an increase in headaches. She reports that she has had intrusive thoughts of ending her life but on exploration of this there appears to be added stress in her marriage.

<Internals\\A & E assessments\\Suicidal ideation\\380\\380> -

2 weeks of feeling stressed, problems in her relation with her about husband

<Internals\\A & E assessments\\Suicidal ideation\\496\\496> -

reported to have been in an abusive marriage. They had been separated  
Impression: long standing unresolved loss issues marriage

<Internals\\A & E assessments\\Suicidal ideation\\84.1\\84.1> -

(name of patient) appeared to be very entrenched in the loss of his marriage

- ongoing marital issues there appears to be high chance of impulsive acts of self-harm attempts to end his life should these issues not be resolved.

## C.2. Sample of coding under the Theme 'Mental Illness- clinician's understanding of self-harm'

<Internals\\A & E assessments\\Self-harm\\01.3\\1.3> -

Impression: pt well-known to PLNs and JHT with BPD and regular related attendances with DSH and regular attendances OD or thoughts of self-harm

<Internals\\A & E assessments\\Self-harm\\049\\49> -

-marked biological signs of depression

*Presents with self-harm* with what appears to be worsening depressive symptoms over the last four months

<Internals\\A & E assessments\\Self-harm\\059.1\\59> -

She has recently been through a number of difficult life events which seem to have impacted on her mental state and exacerbated her depression and DSH

<Internals\\A & E assessments\\Self-harm\\059.2\\59 2nd presentation> -

Most of the self-harm behaviour and state of mood at the time of self-harm were more of Dissociated state rather than in the severe depressive moods with suicidal ideations.

<Internals\\A & E assessments\\Self-harm\\084.2\\84.2> -

Summary: possibly suffering from a repressive illness or adjustment disorder after multiple and chronic loss events with possibly some cluster B features to his PMP.

<Internals\\A & E assessments\\Self-harm\\127\\127> -

Since becoming unemployed in the last 8 weeks he has become low and suicidal and has made 2 suicide attempts in the last 3 days.

Impression: Moderate depression with suicidality

<Internals\\A & E assessments\\Self-harm\\148\\148> -

Deliberate attempt act of self harm.

From cousin's account, diagnosis in behaviour coincides with thyroid operation resulting in ?organic psychosis/affective component.

<Internals\\A & E assessments\\Self-harm\\345\\345> -

Fluctuating thoughts of suicide through starvation and urges to self-harm due to social anxiety

<Internals\\A & E assessments\\Self-harm\\351\\351> -

mental state has deteriorated resulting in severe distress and Self harm

Impression: Relapse of psychotic illness – possible related to change of medication regime.

<Internals\\A & E assessments\\Self-harm\\464\\464.2> -

Impression: Harmful use of alcohol. Mild/moderate depression PD.

Impression: Mild – moderate depressive episode. Harmful misuse of alcohol (alcohol dependence?). Risk of self-harm is high.

<Internals\\A & E assessments\\Self-harm\\499\\499> -

(patient's name) is very depressed and is a high suicide risk.

### C.3. Inductive Coding: Sample of Thematic Categories & Sub-categories during Initial Coding

<b>Thematic Category: Clinicians' formulation of Suicidal Ideation</b>
Alcohol Abuse- clinician's understanding of SI
Environmental Stressors-clinician's understanding of SI
Interpersonal Relatedness- clinician's understanding of SI
Mental Illness- clinician's understanding of SI
Seeking Help- clinician's understanding of SI
Unbearable feelings- clinician's understanding of SI
<b>Thematic Category: Clinicians' formulation of Self-harm</b>
Alcohol Abuse- clinician's understanding of self-harm
Dissociation-clinician's understanding of self-harm
Environmental Stressors- clinician's understanding of self-harm
Impulsivity- clinician's understanding of self-harm
Interpersonal Relatedness- clinician's understanding of self-harm
Mental Illness- clinician's understanding of self-harm
Seeking Help- clinician's understanding of self-harm
Unbearable feelings- clinician's understanding of self-harm



#### C.4: Sample of a Conceptual Category, Thematic Groups & Thematic Categories

Conceptual Category (Level 1)	Thematic Groups (Level 2)	Thematic Categories (Level 3)	Thematic Sub-Categories
Making sense of presentations	Patients' Formulation		
		Suicidal Ideation	
			Hopelessness
			Mental Illness
			Releasing tension-unbearable feelings
		Self-harm	
			Hopelessness
			Mental Illness
			Social problems
			Releasing tension-unbearable feelings
	Clinicians' Formulation		
		Suicidal Ideation	
			Alcohol use
			Environmental Stressors
			Interpersonal Relatedness
			Mental Illness
			Seeking help
			Unbearable feelings
		Self-harm	
			Alcohol
			Dissociation
			Environmental stressors
			Impulsivity
			Interpersonal Relatedness
			Mental Illness
			Seeking help
			Unbearable feelings

## C.5. Deductive coding

### OMMP (Orbach et al., 2003a) coding framework applied to the data

Conceptual Categories	Thematic Categories
<b><i>Irreversibility</i></b>	
	I have lost something that I will never find again The pain will never go away The difficult situation will never change The world has changed forever My life has stopped Something in my life was damaged forever I can't change what is happening to me I can't change what is happening to me.
<b><i>Loss of control</i></b>	
	I am afraid of the future I have no control over the situation There is uncertainty about my life and myself I have no idea what to expect of the future I have no control over my life I am completely helpless I have no control over what is happening inside me I am completely defeated I will fall apart I cannot trust myself
<b><i>Narcissistic wound</i></b>	
	I am rejected by everybody I feel abandoned and lonely Nobody is interested in me Others hate me I am worthless
<b><i>Flooded</i></b>	
	My feelings change all the time There are strong ups and downs in my feelings I feel an emotional turmoil inside me I am flooded by many feelings
<b><i>Freezing</i></b>	
	I feel numb and not alive I feel paralyzed I cannot do anything at all
<b><i>Self-estrangement</i></b>	
	I feel that I am not my old self anymore I feel as if I am not real I am a stranger to myself
<b><i>Confusion</i></b>	
	I cannot concentrate I have difficulties in thinking I feel confused
<b><i>Distancing</i></b>	
	I want to be left alone I need the support of other people (R) I don't feel like talking to other people I can't stay alone (R)
<b><i>Emptiness</i></b>	
	I can't find meaning in my life I have no desires I have no future goals

## C.6. Vignettes for the Focus Groups with the Clinicians

### Vignette 1 \* Psychosocial Assessment at the A & E Department

Ethnicity: Caribbean	Gender: Female
Age: 49	Relationship: Married
Type of accommodation: flat	Employment status: unemployed

Presented: Tuesday, 18<sup>th</sup> January 2011 at 11:20am

Assessed and medically cleared. She did not require suturing. Referred to Psychiatric Liaison.

#### **Presenting Complaint:**

Self-presented with her husband. Elisa suffers from depression. Prescribed citalopram 40mg. She has not been coping and has not been able to sleep recently. Medication does not help her. She had intrusive thoughts of harming herself this morning. Acted on them; cutting her wrist (R) with a kitchen knife and then called her husband who brought her to A & E.

#### **Personal History:**

Elisa lives with her husband who has long standing problems with alcohol misuse. She is worried about him as he is often out drinking with his friends. She denies that he drinks daily. He spends a lot of money on alcohol which has recently resulted in debts: rent (3 weeks behind) and utilities (gas and electricity). Both of them are on benefits. They do not have children but have some contact with local friends.

**Family Psychiatric History:** Nil of note

#### **Medical History:**

-ovarian tumour in 2000; cleared.

#### **Psychiatric History:**

-Depressive Disorder  
- 10/2009: A & E presentation with superficial cuts to wrist  
- 11/2009: Admission following OD  
-has been under the care of a CMHT (psychiatry and nursing); she last saw her CPN approximately 3 weeks ago.

#### **Alcohol and Illicit Drugs:**

Elisa denies use of alcohol and drugs.

#### **Assessment:**

Elisa is a 49 year old Caribbean female, slim, dressed in a red sweater and black trousers, reasonably kempt with short dark hair. She avoided eye-contact; nevertheless, she established good rapport. Her speech was accented but clear. Her speech was of relatively normal volume and rate but had little variation in the tone.

Mood:

Subjective: depressed

Objective: depressed

She has not been sleeping 2/52 during the night. She felt urged to cut her forearms with a kitchen knife 3 days ago. She was unable to say what stopped her then. She did not disclose that to anyone else. She said she had no intent to kill herself then but wished to feel better-felt overwhelmed by debts and husband's problems. She could not resist urges to self-harm today. She consistently denies suicidal intent and claims she wished to alleviate her profound distress.

Appetite decreased. Decreased motivation. She was attending support groups, arranged by her CPN, but missed the last session. She found the group helpful but felt too tired to go last week. Expressed feelings of hopelessness.

Thought:

-FTD: NAD.

-She does not have thoughts to harm others.

-Self-harm thoughts as above.

Content: Preoccupied with debt and husband's drinking. Elisa does not express worthlessness but feels hopeless.

Perception: Denies hallucinations.

Insight: thinks that she is not well and would like to get better.

She is fully orientated. Concentration: mildly impaired.

(\*) Please note that this vignette is fictionalised

## Vignette 2 \*

### Psychosocial Assessment at the A & E Department

Ethnicity: White British	Gender: Male
Age: 26	Relationship: Separated
Type of accommodation: Hostel	Employment status: Unemployed

Presented: Thursday, 13<sup>th</sup> January 2011 at 23:20

Assessed and medically cleared. Referred to Psychiatric Liaison

#### Presenting Complaint:

Brought to A & E by LAS. Ambulance called by another resident further to pt talking about killing himself. Reported to the A & E nurse that he would be killing himself.

#### History of Presenting Complaint:

Pt reports low mood for three years-since death of his mother. Feels rejected by his family and has been drinking more and smoking cocaine. He was in a relationship for five years but separated after Christmas. He has a 3-year-old son. He started drinking beer this afternoon. Drunk 8 cans of beer and later told a resident that he felt like killing himself. He reports that he felt like killing himself as his life is 'shit' (no job, no money, no girlfriend, no family support); he does not have a plan.

Pt wants to be admitted to sort out his drinking and life.

#### Psychiatric History:

- OD attended A & E in 2005. Discharged.
- reports has self-harmed (cutting) in the past.
- denies having seen a psychiatrist
- ?prescribed fluoxetine by his former GP; unclear reports.

**Medical History:** Nil of note.

#### Use of Illicit Drugs & alcohol:

- Drinking excessively since his Mother's death. He reported withdrawal symptoms (sweating, tremor)
- Regular use of cannabis.

#### Family History:

Denied family history of psychiatric disorders. His Mother died from heart failure; his Father is alive and lives in Essex. He has siblings; however, he has had a poor relationship with his family since his Mother's death.

#### Personal History:

He lived with his girlfriend but they separated after Christmas. He now lives in a hostel of the probation service; he informs me he is on a license. He is estranged from his family and friends. He does not like the other residents. He is currently unemployed.

He has a 3-year-old son who lives with his Mother. His son is a protective factor. He smacks his son when he is naughty- he jumps, climbs a lot and does not do as he is told.

**Forensic History:**

Robberies to buy drugs and alcohol. He was caught 2 years ago and received a sentence. Reports he has not offended since released.

**Mental State Examination:**

This is a 26-year-old White British male, slightly built, unkempt, unshaven with missing teeth and casually dressed. Appeared older than his chronological age. Good eye contact. Good rapport. Speech: normal in tone, rate and volume. Recent sleep disturbance. Appetite: good. Not aggressive, not hostile. No psychomotor retardation.

Formal thought disorder: Nil

Suicidal thoughts/ no thoughts of harming others.

Abnormal beliefs/ perceptions: Nil

Hallucinations: Nil

Content: preoccupied with separation from his girlfriend and estrangement/ rejection by his family.

Mood:

Subjective: he has had enough.

Objective: euthymic and reactive.

Cognition: intact. Fully orientated (time/place/person).

Insight: Recognises his alcohol problem but not drug misuse. He has not engaged with community drug & alcohol services.

He does not see a future for himself unless he gets admitted.

(\*) Please note that this vignette is fictionalised

## C.7. Question Routes for the Focus Groups with the Clinicians

### Question Route for the 1<sup>st</sup> Focus Group

<b>Spontaneous Thoughts</b>	Prompt: What is the first thing that comes to mind? (if required)
<b>Formulation</b>	<p>How do you make sense of Elisa and her difficulties? What kinds of formulations can we make about Elisa and her difficulties? What are some of your ideas? How do you understand her difficulties?</p> <p>What about Elisa's husband? Would you involve him?</p> <p>Would you think some of Elisa's difficulties are often present in other people who self-harm?</p>
<b>Feelings</b>	<p>Let's imagine you were in a cubicle with Elisa, what emotional responses would you have? How would you feel?</p> <p>Is this a typical reaction? What about other people who self-harm? What about people who regularly attend?</p>
<b>Care plan</b>	<p><b><u>What treatment plan would you offer? How would you decide what treatment to offer?</u></b></p> <p>Characteristics in Elisa's personality and care planning? Emotional responses and care planning?</p> <p>Thinking of people who self-harm: <b>What are the most important factors for you in deciding what treatment to offer to people who self-harm?</b> Statutory &amp; voluntary sector.</p> <p>What about those who repeatedly present?</p> <p>NICE/ DSM/ICD: do you find that there are patients that do not fit in with the classification system?</p>
<b>Validity</b>	<b>Is this a plausible vignette? Did it sound real?</b>
<b>Closing</b>	<p><b><u>If you had one minute, of all the things we discussed, which one is the most important to you?</u></b></p> <p>Have we missed something? Is there anything else that we should have talked but we did not?</p>

## Question Route for the 2<sup>nd</sup> Focus Group

<b>Spontaneous Thoughts</b>	Prompt: What is the first thing that comes to mind? (if required)
<b>Formulation</b>	<p>What kind of formulations do you make about this patient and his difficulties? What are some of your ideas? How can we make sense of his difficulties?</p> <p>Would you think some of his difficulties are often present in other people with suicidal ideation?</p> <p><i>What about people who regularly attend A&amp;E for treatment?</i></p> <p><i>What about his child?</i></p>
<b>Care plan</b>	<p><b><u>What treatment plan would you offer? How would you decide what treatment to offer?</u></b> what would be the hope?</p> <p>Thinking of people who self-harm:  <b>What are the most important factors for you in deciding what treatment to offer to people who self-harm?</b> Statutory &amp; voluntary sector.</p> <p>Would you see a role for the GP? If so, what action?</p> <p>What if he comes back? represents with self-harm?</p> <p>How do you feel people who present to A&amp;E following self-harm should be treated?</p>
	<p>How would you relate to this patient?</p> <p><i>If the person has a psychiatric diagnosis, how would you feel-would that change the way you relate to him?</i></p>
<b>Validity</b>	<b>Is this a plausible vignette? Did it sound real?</b>
<b>Closing</b>	<p><b><u>If you had one minute, of all the things we discussed, which one is the most important to you?</u></b></p> <p>Have we missed something? Is there anything else that we should have talked but we did not?</p>



**Care Plan Goals from last group- COMPARE:**

- *Achievable/ Realistic/ Available*
- *Not making promises other Health Care Professionals will be able to keep*
- *Containment in a crisis*
- *Safety!- Fully assess risk of completed suicide*
- *Allow time for things to change (this may be facilitated by admission if necessary)*
- *Evidence based treatment for defined disorders (NICE guidelines)*
- *Any considerations based on the Mental Health Act*
- *Patient agreement to plan ('signing-up' or 'buying-in')*
- *Presenting options to them but not overload them*

## **C.8. A Sample of Field notes from the first focus group**

### **Introductions:**

'H' was the first to enter the room and was followed a few minutes later by the rest of the group. The purpose of the session, confidentiality requirements and procedures were explained. When asked if they had had an opportunity to read the preparatory literature and consent forms all members stated that they had not. It was also acknowledged that two would-be members, who had previously communicated their intent to attend, had not arrived to take part.

On initial impressions of the group 'H' appeared most interested in the purpose of the research and keen to engage in it. 'R' and 'C' seemed more reserved in their deportment and 'B', both in opening comments and body positioning, looked positively reticent to take part.

The vignettes were distributed and the group was given time to examine the case. This took a few minutes, some members of the group finishing before others. 'H' took this opportunity to re-read the vignette. 'B' and 'C' did this also however their flourish in 'flipping-back' to the first page, in conjunction with stolen glances left me with the impression they were perhaps signalling an impatience with 'R' who was last to finish.

### **Reactions to Vignette:**

On being asked to volunteer any initial impressions or thoughts in response the group remained silent for an extended pause. 'C' was first to comment that, in her opinion, not many middle-aged Afro-Caribbean women presented at A&E with self-harm. This was in agreement with the group who appeared to agree that it would be 'unusual'. Indeed, 'C' continued, not many self-harmers would be likely to present "*...in the morning*". On this point 'B' contributed that such a presentation would be more common at night alongside alcohol

use. 'R' followed by questioning the likelihood of the patient's husband attending also, particularly at the time of day suggested.

The coalescence of the group's comments at this stage could be seen as questioning the believability of the vignette from the outset. This raised a question in the mind of the observer as to whether the group might be mobilising to undermine the endeavour?: Using the amassed 'reality' of its considerable front-line experience to challenge the legitimacy of a case vignette presented to them as part of 'academic' research.

### **Considering biographical/social factors:**

Thus far the consensus that was the presentation in the vignette was unusual. However 'H' introduced the thought that the self-harm 'unusual' nature of the presentation might ring "*alarm-bells*" for him. Indeed he went on to speculate that this might be evidence of a failed suicide attempt and suggest that would factor into his assessment. While the group did not explore this specific idea in more depth, 'H's contribution appeared to prompt a more holistic discussion of the case in the group. In a more sympathetic tone 'B' raised the patient's history of ovarian cancer as potentially influential factors. In a similar manner debt problems mentioned in the vignette were also raised for the first time.

### **Arriving at a formulation:**

The group were prompted to consider what investigative or other steps they might take. Picking up on previous CMHT involvement in the case 'C' set out a plan of action whereby she would contact the CPN involved to gather information. She also floated the idea of seeing whether the CPN might "...*see her first*". 'B' spoke to flag the potential relevance of the cases previous admission while 'R' raised the issue of possible issues of complying with medication.

During this period there appeared to be a divergence in the group's approach: 'R', and to a lesser extent 'B', appeared more content to wonder openly about the potential relevance of background aspects contained within the vignette. In contrast to this 'H' and 'C' seemed keen to emphasise a very proactive and businesslike approach which seemed to advocate getting to the source of the problem through contacting the Health Professional most involved with the case to date. In 'B's case this approach is perhaps partially undermined by her suggestion that the CPN could be called in *prior* to her own involvement. While no one in the group challenged this idea I wondered if this might be realistic as a viable, timely response to the presentation.

Perhaps in response to the inherent problem of 'not knowing', when speculating as to the causes of a problem, 'H' acknowledged the "*medical-model*" approach he was given to adopt. He put forward the idea that a "*psychiatric history*" might be a label that was potentially misleading and put forward a two stage process to assessment: Firstly to establish the relevancy of past history (if any); secondly to consider whether more recent issues (debt/partner's reported alcohol use) had precipitated the presentation at A&E.

### **Working with the husband?**

Initial discussion about the propriety of involving the husband in the work seemed to begin, at least in the minds of 'B', 'C' and 'R', from a position of initial suspicion. Noting the reported, yet deliberately unquantified, involvement with alcohol both 'B' and 'C' stated that they would proceed by trying to have a private conversation with Elisa first. They would then consider engaging with her husband depending on their assessment of that conversation. Citing the potentially valuable information that can be provided by 'Third party informants', 'H' considered that it might also be appropriate to see the husband on *his* own. He also posited

another potential narrative in which the husband's drinking might not necessarily be 'problematic' (except in the eyes of his wife) and itself a response to the difficulties of caring for a partner with mental health problems. Furthermore, what if a conversation were had in which the husband disclosed he couldn't cope and refused to take his wife home upon discharge? 'R' agreed that this would change the care plan dramatically.

This section of the session prompts several thoughts. Superficially at least it could be argued that practitioners aligned themselves with their own genders- the women in the group adopting a protective response as default. However perhaps their disclosure that they had evolved specific tactics, enabling them to have private conversations with women in the past, hints at having been conditioned by presentations of both partners in which they suspect domestic violence for example. 'H's contributions were helpful in that they highlighted the assumptions the rest of the group had been quick to make. Interestingly, in inviting other potential narratives, 'H' might arguably be seen to be indulging in the kind of speculative thought he had previously sought to minimise.....

## C.9. Sample of Coding under the Thematic category: Emotional Impact on Clinicians

<Internals\Focus Group clinicians\Focus Group 1 audio\Focus Group 1> - § 13 references coded [100.00% Coverage] Reference 1 - 100.00% Coverage

er is it's made me realise that we er (...) we don't have any - although we've got a staff support group and clinical supervision daily kind of thing, er I, I very rarely ask myself the question, "How is this affecting me emotionally? What's my counter transference, la, la, la, la?" We just don't do it *[high tone]*. I, I kind of might note it (...) myself as I did and shared that with you but I would not have shared that with the team and I don't, I don't hear team members talking much about that. People sometimes come in and a let off a bit of steam but we don't analyse our emotional response to the work much I would say and it's sort of brought that home to me. Certainly among the doctors we don't.

Reference 2 - 100.00% Coverage

Well as I say the structures are there where we potentially could do it, we just don't and I suppose that might need a bit of revisiting.

Reference 3 - 100.00% Coverage

I suppose for some nurses it's quite different isn't it because erm me certainly I would have picked up, you get individuals who see patients and come back to the office and erm you can see some people bring in their emotions into it, erm particularly nurses.

Reference 4 - 100.00% Coverage

Yeah but they're not naming them.

Reference 5 - 100.00% Coverage

No.

Reference 6 - 100.00% Coverage

They're, you know they're, they're not even maybe recognising that that's projective identification or projection or transference or whatever (...) because we don't, we're not in a culture where we actually do that. You know, you might get somebody coming in who's really angry but they don't know why they're angry you know (...) and you might think, "Oh they're in a bad mood" or they're - but it's actually stepping back from it really (...) looking at what, what it was with that patient because (...)

Reference 7 - 100.00% Coverage

It's more - sometimes it's the referrer that we're - the referrer we're angry with

Reference 9 - 100.00% Coverage

- rather than the patient.

Reference 11 - 100.00% Coverage

I suppose honestly there are times when people go and see patients and can go, "This patient is really doing my head in". They don't - people don't say they're angry. People say that most, you know, I've heard it many times or it's like -

Reference 12 - 100.00% Coverage But it's the recognising why.

**C.10. A sample of the coding scheme developed- Conceptual Category:  
Relating to Patients**

Conceptual Category	Thematic Groups	Thematic Categories
Relating to Patients	Attitudes	Coercive Curiosity Confidence Difference Insight/ Empathy Manipulative feel Sympathy/Caring Assumptions Difference Uncaring
	Emotional States	Emotional responses Influencing factors Impact on clinicians/ Clinicians' reflection

### **C.11. Ethics Approval**

An application for ethics approval was initially submitted to the National Research Ethics Committee (Camden & Islington) and subsequently two notices of amendments were submitted following communication with the National Research Ethics Committee. A favourable opinion was received. In addition, a notification was submitted to the University Research Ethics Committee (UEL).

The current appendix includes:

- 1) Letter by the Camden & Islington Research Ethics Committee dated 6 October 2009
- 2) Letter by the North West London Research Ethics Committee dated 15 December 2010
- 3) Letter by the National Research Ethics Service London (Camden & Islington) dated 4 July 2011
- 4) Letter by the University Ethics Committee





## National Research Ethics Service

### Camden & Islington Community Research Ethics Committee

REC Offices  
South House, Royal Free Hospital  
Pond Street, London  
NW3 2QG

Telephone: 020 7794 0500 extn 36906  
Facsimile: 020 7794 1004

06 October 2009

Professor Stephen Briggs  
Director of Centre for Social Work Research  
Tavistock and Portman NHS Foundation Trust  
Tavistock Centre  
120 Belsize Lane  
London  
NW3 5BA

Dear Professor Briggs

**Study Title:** A study of patients referred following an episode of self-harm, a suicide attempt or in a suicidal crisis using routinely collected data

**REC reference number:** 09/H0722/68  
**Protocol number:** Version 3

The Research Ethics Committee reviewed the above application at the meeting held on 28 September 2009. Thank you for attending to discuss the study.

#### Ethical opinion

The members of the Committee present gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

#### Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

#### Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

This Research Ethics Committee is an advisory committee to London Strategic Health Authority  
The National Research Ethics Service (NRES) represents the NRES Directorate within  
the National Patient Safety Agency and Research Ethics Committees in England

*For NHS research sites only, management permission for research ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements. Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>. Where the only involvement of the NHS organisation is as a Participant Identification Centre, management permission for research is not required but the R&D office should be notified of the study. Guidance should be sought from the R&D office where necessary.*

*Sponsors are not required to notify the Committee of approvals from host organisations.*

**It is responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).**

#### **Approved documents**

The documents reviewed and approved at the meeting were:

Document	Version	Date
Covering Letter		11 August 2009
REC application		
Protocol	Version 3	31 July 2009
Investigator CV	C.I.s CV - Prof. Stephen Briggs	31 July 2009
Referees or other scientific critique report	Reviewer - Andrew Cooper, Tavistock & Portman NHS Trust	23 July 2009
Letter from funder	SLaM Charitable Funds	26 February 2009

#### **Membership of the Committee**

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

#### **Statement of compliance**

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

#### **After ethical review**

Now that you have completed the application process please visit the National Research Ethics Service website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments

This Research Ethics Committee is an advisory committee to London Strategic Health Authority  
The National Research Ethics Service (NRES) represents the NRES Directorate within  
the National Patient Safety Agency and Research Ethics Committees in England



- Adding new sites and investigators
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email [referencegroup@nres.npsa.nhs.uk](mailto:referencegroup@nres.npsa.nhs.uk).

09/H0722/68

Please quote this number on all correspondence

With the Committee's best wishes for the success of this project.

Yours sincerely



**Ms Stephanie Ellis**  
Chair

Email: [katherine.ouseley@royalfree.nhs.uk](mailto:katherine.ouseley@royalfree.nhs.uk)

*Enclosures: List of names and professions of members who were present at the meeting and those who submitted written comments*

*"After ethical review – guidance for researchers"*

*Copy to: Sponsor's contact - Dr Louise Lyon, Tavistock and Portman NHS Foundation Trust*

*Research Governance contact – Prof. Andrew Cooper, Tavistock and Portman NHS Foundation Trust*



## National Research Ethics Service

### North West London REC 1

REC Office  
Maternity, Level 7  
Northwick Park Hospital  
Watford Road  
Harrow  
HA1 3UJ

Tel: 020 8869 5446  
Fax: 020 8869 5222

15 December 2010

Professor Stephen Briggs  
Director of Centre for Social Work Research  
Tavistock and Portman NHS Foundation Trust  
Director of Centre for Social Work Research  
Tavistock Centre  
120 Belsize Lane  
London  
NW3 5BA

Dear Professor Briggs

**Study title:** A study of patients referred following an episode of self-harm, a suicide attempt or in a suicidal crisis using routinely collected data.  
**REC reference:** 09/H0722/68  
**Amendment number:** Briggs & Glen-Day Revised 6 November 2010 Version 4.2  
**Amendment date:** 25 November 2010

The above amendment was reviewed by the Sub-Committee in correspondence.

#### Ethical opinion

The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

#### Approved documents

The documents reviewed and approved at the meeting were:

Document	Version	Date
Vignette 2	2	08 November 2010
Vignette 1	2	08 November 2010
Participant Consent Form	1	04 November 2010
Participant Information Sheet: Phase 2	2.1	04 November 2010
Protocol	Revised Version 4.2	06 November 2010
Notice of Substantial Amendment (non-CTIMPs)	Briggs & Glen-Day Revised 6 November 2010 Version 4.2	25 November 2010

#### Membership of the Committee

The members of the Committee who took part in the review are listed on the attached sheet.

This Research Ethics Committee is an advisory committee to London Strategic Health Authority  
The National Research Ethics Service (NRES) represents the NRES Directorate within  
the National Patient Safety Agency and Research Ethics Committees in England

#### **R&D approval**

All investigators and research collaborators in the NHS should notify the R&D office for the relevant NHS care organisation of this amendment and check whether it affects R&D approval of the research.

#### **Statement of compliance**

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

**09/H0722/68:**

**Please quote this number on all correspondence**

Yours sincerely



**Ms Louise Braley**  
**Committee Co-ordinator**

E-mail: [louise.braley@nhs.net](mailto:louise.braley@nhs.net)

*Enclosures:* *List of names and professions of members who took part in the review*

*Copy to:* *Dr Louise Lyon*



**National Research Ethics Service**  
NRES Committee London - Camden & Islington

REC Office  
Maternity, Level 7  
Northwick Park Hospital  
Watford Road  
Harrow  
HA1 3UJ

Tel: 020 8869 5446  
Fax: 020 8869 5222

04 July 2011

Professor Stephen Briggs  
Director of Centre for Social Work Research  
Tavistock and Portman NHS Foundation Trust  
Tavistock Centre  
120 Belsize Lane  
London NW3 5BA

Dear Professor Briggs

**Study title:** A study of patients referred following an episode of self-harm, a suicide attempt or in a suicidal crisis using routinely collected data.  
**REC reference:** 09/H0722/68  
**Amendment number:** Briggs & Glen Day Revised 20 April 2011 Version 5.1  
**Amendment date:** 20/04/2011

The above amendment was reviewed by the Sub-Committee in correspondence.

**Ethical opinion**

The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

**Approved documents**

The documents reviewed and approved at the meeting were:

Document	Version	Date
Vignette	1	15 April 2011
Questionnaire	2	26 May 2011
GP/Consultant Information Sheets	1.1	26 May 2011
Participant Consent Form: for GPs	1	08 April 2011
Participant Consent Form: for Service-users		26 May 2011
Participant Information Sheet: for GPs	2	08 April 2011
Participant Information Sheet: for Service-users	1.1	26 May 2011
Protocol	5.1	20 April 2011
Notice of Substantial Amendment (non-CTIMPs)	17969/220380/13/469/4570	09 June 2011

**Membership of the Committee**

The members of the Committee who took part in the review are listed on the attached sheet.

This Research Ethics Committee is an advisory committee to London Strategic Health Authority  
The National Research Ethics Service (NRES) represents the NRES Directorate within  
the National Patient Safety Agency and Research Ethics Committees in England

#### **R&D approval**

All investigators and research collaborators in the NHS should notify the R&D office for the relevant NHS care organisation of this amendment and check whether it affects R&D approval of the research.

#### **Statement of compliance**

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

**09/H0722/68:**

**Please quote this number on all correspondence**

Yours sincerely



**Ms Louise Braley**  
**Committee Co-ordinator**

E-mail: [louise.braley@nhs.net](mailto:louise.braley@nhs.net)

*Enclosures:* *List of names and professions of members who took part in the review*

*Copy to:* *Dr Louise Lyon*



**GRADUATE SCHOOL**

Director: Alan White, BA(Hons) PhD  
[uel.ac.uk/gradschool](http://uel.ac.uk/gradschool)

Ms Antigone Gkaravella  
157 Ebbett Court  
Victoria Road  
London  
W3 6BX



6 June 2014

Dear Ms Gkaravella

**University of East London/The Tavistock and Portman NHS Foundation Trust:  
research ethics**

**Study Title:** *A study of the experiences of patients who present in an Accident and Emergency Department with a self-harm episode, a suicide attempts or a suicidal crisis, and the aftercare provided by General Practitioner.*

I am writing to inform you that the University Research Ethics Committee (UREC) has received NHS documentation regarding the above study, which was submitted to the Chair of UREC, Professor Neville Punchard. Please take this letter as written confirmation that had you applied for ethical clearance from our UREC at the appropriate time; it is likely it would have been granted. However, this does not place you in exactly the same position you would have been in had clearance been obtained in advance. Therefore, when responding to any questioning regarding the ethical aspects of your research, you must of course make reference to and explain these developments in an open and transparent way.

For the avoidance of any doubt, or misunderstanding, please note that the content of this letter extends only to those matters relating to the granting of ethical clearance. If there are any other outstanding procedural matters, which need to be attended to, they will be dealt with entirely separately as they fall entirely outside the remit of our University Research Ethics Committee.

If you are in any doubt about whether, or not, there are any other outstanding matters you should contact Mr William Bannister at the Tavistock and Portman NHS Foundation Trust (e-mail [WBannister@tavi-port.nhs.uk](mailto:WBannister@tavi-port.nhs.uk)).

Yours sincerely

pp: Catherine Fieulleateau  
Ethics Integrity Manager  
**For and on behalf of**  
Professor Neville Punchard  
Chair of the University Research Ethics Committee (UREC)

Tel.: 020 8223 6683 (direct line)  
E-mail: [c.fieulleateau@uel.ac.uk](mailto:c.fieulleateau@uel.ac.uk)

Docklands Campus, University Way, London E16 2RD  
Tel: +44 (0)20 8223 2674/7097 Fax: +44 (0)20 8223 2826 MINICOM 020 8223 2853





## **C.12. Participant Information Sheet**

**A study of patients referred following an episode of self-harm,  
suicide attempt or in suicidal crisis using routinely collected data,  
and interviews with clinicians and GPs**

### **Phase 2**

### **Participant Information Sheet**

#### **Part 1: Essential Information**

We would like to invite you to take part in a research study. Before you decide we would like to outline why the research is being done and what it would involve for you. Please take time to read the following information carefully. You can talk to others about the study if you wish. Part 1 explains the purpose of the study and what will happen if you take part. Part 2 gives more detailed information about the conduct of the study. Ask us if there is anything that is not clear, or if you would like more information. Please take time to decide whether or not you wish to take part.

#### **1.1 Purpose of the study**

A study has been undertaken investigating the relationship between background social factors, psychiatric diagnoses, and suicidal/self-harming histories, and the treatments offered to people who presented with self-harm, suicide attempt or suicide crisis in the Accident and Emergency Department of St Thomas Hospital (Phase 1). We would now like to move on to explore further the process of assessment and assessment outcomes and more specifically, clinicians' experiences, beliefs, feelings, and ways of thinking and drawing conclusions during an assessment.

#### **1.2 Why have I been invited?**

You have been invited to participate as you are a clinician in the Psychiatric Liaison Team and are involved in assessments of patients presenting at the Accident and Emergency Department of St Thomas Hospital following an episode of self-harm, suicide attempts or in suicidal crisis. Your contributions will be exceptionally valuable and will hopefully allow us to take our work forward in this important area.

#### **1.3 Do I have to take part?**

It is up to you to decide whether to participate or not. We will describe the study and go through this information sheet, which we will then give to you. Following that, we will ask you to sign a consent form to show you have agreed to take part. You can withdraw at any time, without giving a reason. This will not affect your employment in the South London and Maudsley NHS Foundation Trust or impact in any way on your future interaction with the Tavistock and Portman NHS Foundation Trust and the University of East London.

#### **1.4 What will it happen if I take part?**

You will take part in a focus group (alongside your colleagues in the Psychiatric Liaison Team) who will meet for about one hour and fifteen minutes on two occasions. On each occasion, you will be provided with a fictionalised but realistic vignette, and ask to reflect and share with us your thoughts. Focus groups will be facilitated by Antigone Gkaravella and a Research Assistant of the Centre for Social Work Research. The discussion will focus on your and your colleagues' thoughts and reflections. The agenda will however be flexible, so that you can raise the issues of particular relevance to you and your clinical practice. The focus group will be tape recorded, transcribed into print and then analysed by the researchers. Notes will also be kept. Following that, we will provide you with a summary of the main findings and invite you to comment on these either verbally or in writing.

#### **1.5 What are the possible benefits and disadvantages of taking part?**

This study involves discussing the assessment process for patients who self-harm, attempt suicide or are in suicidal crisis. In other words, it focuses on your routine clinical practice and therefore, it is not anticipated that harm may be caused to you. It is possible that, depending on the issues discussed, this could be difficult for you. Whilst your peers within the focus group may provide support, you are free to leave if you wish. If you experience distress, whether or not you remain in the group, please do discuss this in confidence with us. We cannot promise that this study will help you personally. However, the information we get from this study will hopefully help our understanding of the experiences of patients who present for an emergency assessment, the experiences of the clinicians who offer the assessment as well as the overall assessment process. This, in turn, may be beneficial to the treatment of people with self-harm, suicide attempts or in suicidal crisis. We cannot though guarantee that this will be the case.

#### **1.6 What happens when the research study stops?**

You will be provided with a summary of the main findings and you will have the opportunity to provide comments verbally and/or in writing, and may do so anonymously if you wish. Please note that your managers will be provided with the findings which will though include no identifiable information about the participants. It is hoped that the findings will provide important information about improving services for people who self-harm, attempt suicide or are in suicidal crisis.

#### **1.7 What if there is a problem?**

Any complaint about the way you are dealt with during the study or any harm you might suffer will be addressed. The detailed information on this is given in Part 2.

#### **1.8 Will my taking part in the study be kept confidential?**

Your participation to the study will be kept anonymous and confidential. We will follow ethical and legal practice and all information about you will be handled in confidence. The details are included in Part 2.

If the information in Part 1 has interested you and you are considering participation, please read the additional information in Part 2 before making any decision.

## **Part 2: Additional Information**

### **2.1 What will happen if I do not want to carry on with the study?**

As previously mentioned you can withdraw from the study at any point. We will destroy any identifiable data and you will receive no further contact regarding this study. However, we may need to use the data collected up to the point of your withdrawal.

### **2.2 What if there is a problem?**

If you have a concern about any aspect of this study, you are invited to speak to the researchers who will do their best to answer your questions (contact numbers are included at the end of the information sheet). If you remain unhappy and wish to complain formally, you can do this through the NHS Complaints Procedures. In the unlikely event that you are harmed during the research and this is due to someone's negligence, then you may have grounds for legal action. The usual National Health Service complaints mechanisms will still be available to you.

### **2.3 Will my taking part in the study be kept confidential?**

All information that is collected about you during the course of the study will be kept strictly confidential. We will ask participants to not disclose any patient information during the discussion and to maintain confidentiality in relation to their colleagues' contributions. You will not be personally identifiable in the typed transcription (you will be given a pseudonym) or in any subsequent verbal or written account. Audiotapes will be stored securely in locked premises and electronic material will be password protected. Your information will not be used or made available for any purpose other than for this research. If the collected data is used for future studies, Ethical Approval will be sought. It may be that anonymous samples of the data are looked at by associate researchers for monitoring of the quality of the research. The same principles of Data Protection Act will apply and all will have a duty of confidentiality to you as a research participant. Data will be retained for five years and will subsequently be disposed securely. The aforementioned principles will apply to all participants. However, if concerns about the safety of patients and staff emerge, these will be thought of with the management of the team (NHS Whistleblowing policy).

### **2.4 What will happen to the results of the study?**

Following completion of the study, a summary of the findings will be sent to you and your managers. We will, subsequently, offer you the opportunity to provide comments verbally and/or in writing and may do so anonymously if you wish. Furthermore, the findings will be presented in a thesis for a professional doctorate in social work. Participants will not be identified in any report.

### **2.5 Who is organising and funding the research?**

The study is being organised by the Tavistock and Portman NHS Foundation Trust and the University of East London. The initial study was funded by the South London and Maudsley Trust Charitable Funds (Phase 1). The current study is partly undertaken for a professional doctorate in social work and is sponsored by the Tavistock and Portman NHS Foundation Trust.

### **2.6 Who has reviewed the study?**

All research in NHS is looked at by an independent group of people, namely a Research Ethics Committee to protect your safety, rights, welfare and dignity. This research study has been reviewed and given favourable opinion by the North West Research Ethics Committee 1. In

addition, it was reviewed and given favourable opinion by the Registration Board and the Postgraduate Research Degrees Committee of the University of East London.

## **2.7 Further information and contact details**

If you would like further information about this research, please contact

Professor Stephen Briggs, Principal Investigator  
Director of Centre for Social Work Practice  
Email: sbriggs@tavi-port.nhs.uk  
Tel:

Antigoni Gkaravella, Student  
Email: agkaravella@tavi-port.nhs.uk  
Tel:

**Thank you for taking the time to read this.**

**Please take time to decide whether or not you wish to take part in this study.  
You will be given a copy of this information sheet and a signed consent form to keep.**

### C.13. Consent Form

Study Number: 09/H0722/68

Participant Identification:

#### CONSENT FORM

Title of Project: 'A Study of patients referred following an episode of self-harm, suicide attempt or suicidal crisis using routinely collected data, and qualitative interviews with clinicians and GPs'.

Name of Researchers: Professor Stephen Briggs (Principal Investigator) and Antigoni Gkaravella

Please initial box to indicate agreement

1	I confirm that I have read the information sheet dated 4 <sup>th</sup> November 2010 (version 1) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
2	I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my employment or legal rights being affected.	
3	I understand that relevant sections of data collected during the study, may be looked at by individuals from the Tavistock and Portman NHS Foundation Trust, from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to the data.	
4	I agree to my managers being provided with an anonymised summary of the main findings.	
5	I agree to take part in the above study.	

\_\_\_\_\_  
Name of Participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Name of Person taking consent

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

When completed: 1 copy for participant; 1 copy (original) for researcher file

## Appendix D

### D.1.: Socio-demographic factors at initial presentation (index episode)

Number of Individuals	N*=40	Ideation n*=20	Self-harm n*=20
<b>Socio-demographic factors</b>			
<b>Gender</b>			
Female	18	9	9
Male	22	11	11
<b>Age at index</b>			
18–19	4	2	2
20–29	9	4	5
30–39	9	3	6
40–49	8	7	1
50–59	5	2	3
> 60	5	2	3
<b>Ethnicity</b>			
White British	16	10	6
White European	4	1	3
White Other	7	2	5
Irish	0	0	0
Black British	1	1	0
Black Other	8	5	3
Asian	3	1	2
Not known	1	0	1
<b>Marital status</b>			
Married/partner	14	8	6
Divorced/separated	5	3	2
Widowed	2	0	2
Single	7	3	4
Not known	12	6	6
<b>Housing status</b>			
Flat/House	23	14	9
Supported Living	3	0	3
Hostel	6	3	3
Homeless	5	2	3
Temporary living with others	2	0	2
Inpatient ward	1	1	0
<b>Parent with young child/ren</b>			
No	33	17	16
Yes	7	3	4
<b>Employment</b>			
Full/part-time	6	3	3
Sick leave	2	1	1
Retired	2	2	0
Student	3	1	2
Not working	20	10	10
Not known	7	3	4

Number of Individuals	N*=40	Ideation n*=20	Self-harm n*=20
<b>Previous psychiatric treatment</b>			
No	7	3	4
Yes	26	13	13
Not known	7	4	3
<b>Previous self-harm</b>			
No	10	4	6
Yes	24	11	13
Not known	6	5	1

\* N= total number of patients; n= number of patients in each cluster of presentations at the index episode

## D.2. History of Self-harm

### Nature of past self-harm at the index episode

<i>Nature of self-harm</i>	<i>Total No of patients N =40</i>	<i>Patients initially presenting with Suicidal Ideation n=20</i>	<i>Patients initially presenting with Self-harm n=20</i>
Self-poisoning	8	4	4
Self-cutting	2	-	2
Self-cutting & self-poisoning	5	3	2
Jumping into the Thames	1	1	-
Hanging	1	-	1
Jumping from height	1	-	1
Self-hitting	1	-	1
Self-hitting & suffocating	1	1	-
Various	4	2	2
None/ Not known	16	9	7



### D.3. Characteristics of Presentations with Suicidal Ideation (N\*=29)

Presenting Complaint		Number of presentations =29
Presenting Complaint		
	Intent to commit suicide	3
	Tiredness of Life	0
	Death Wishes	3
	Death Wishes & Suicidal thinking	2
	Suicidal Thinking	21
Alcohol Consumption prior to the presentation		
	Yes	18
	No	11
Method of arriving to A& E		
	London Ambulance Service –patient calling	4
	London Ambulance Service- other calling	7
	London Ambulance Service- unknown caller	3
	Police	4
	By themselves	6
	Not known	4
	Transferred from outpatient clinic	1
Time of Presentation		
	Working hours	8
	Out of office hours	21
Escorted by family/ friends		
	Yes	7
	No	22

\* N= number of SI presentations

#### D.4. Characteristics of Presentations with Self-harm (N\*=32)

Presenting Complaint		Number of presentations = 32
	Self-poisoning	15
	Cutting	8
	Jumping into Thames	3
	Hanging	2
	Jumping from height	1
	Self-burning	1
	Self-hitting	1
	Self-poisoning & cutting	1
Use of alcohol before presentation		
	Yes	7
	No/not recorded	25
Method of arriving to A& E		
	London Ambulance Service – patient calling	7
	London Ambulance Service- other calling	8
	London Ambulance Service- unknown caller	3
	Police	2
	By themselves	2
	Not known	10
Time of Presentation		
	Working hours	11
	Out of office hours	21
Escorted by family/ friends		
	Yes	10
	No	22

\* N= number of SH presentations

## Appendix E

### Appendix E.1

- Peter: *Hmm. I mean the way I'd get at that is what I would do is if someone's 49 and they've just discovered that cutting gives them tension relief, I'd explore that and see whether they are giving me a convincing story of cutting for tension relief and how they hit upon that at the age of 49 all of a - and if they can't really convince me that they've hit upon it then I'll be thinking, this isn't what this is about, do you see what I mean?*
- Facilitator: *Yes, please carry on...*
- Peter: *And then it takes you back to, well maybe she's - so I guess I've got a sort of stereotyped idea in my mind of what people who cut for relief, how they would describe that phenomenologically and if they don't give me that then it'll take me back to, well what was this cut then?*

### Appendix E.2

- Harun: *...kind of moving towards - once you've got all this information, had a chat with him and he's sobered up and, I suppose, the other thing is suicidal intent. So we know he's having suicidal thoughts.*
- Facilitator: *Yeah.*
- Harun: *No suicidal planning. Does he have suicidal intent? Does he actually think that he's going to do something um and the other thing is, would he call for help if he felt that [it would happen] because he has done on this occasion...*
- Lorna: *Mmm.*
- Harun: *...by telling someone. If he gets to that point again is he going to call for help again? That's often a key question for - in deciding your management because the home treatment team, for example, will want to know the patient can guarantee their safety um so, yeah, that's another thing and it says here that he, he doesn't see a future for himself unless he gets admitted. But I'd like to...*
- Facilitator: *Mm-hm.*
- Lorna: *[explain]*
- Harun: *...kind of elaborate on that a bit and talk to him about his life and what he plans to do because he can say I don't see a future but if you ask him things like when are you going to see your son next, then he might tell you and asking questions like that which might suggest that he does have some plans for the future or maybe not.*

### Appendix E.3

- Peter: *Hmm but then the flip side of that is that, that er, I would want to ask him on his own er whether, regardless of whether she knows that's happening, I'd want to ask him on his own if there's anything he wants me to be aware of about the incident or about the recent health.*
- Marie: *Well yeah, hmm.*
- Peter: *Er (...) because we do get complaints from family and friends who have brought people to the ... not formal complaints but we get, you know, one of the, one of the things that goes wrong is that family or friends accompany people to A&E with self harm, hang around the waiting room and then don't get approached to see what concerns they're wanting to share with us and -*
- Marie: *Hmm that's -*
- Peter: *- I, I try and just -*
- Anne: *I always go to get them -*
- Marie: *Well that's normally on our catch list.*

### Appendix E.4

- Lorna: *I suppose there's the sort of, for me it was the kind of assumption erm (.....) that when you pick up a case or read about a case, the sort of assumption and stereotype ideas that already suddenly erm runs out.*
- Facilitator: *So, tell us a bit more, are you talking about your -*
- Lorna: *Exactly, you know picking up this like Caribbean, 49, single, self-harm, it doesn't happen [laughs] so you know, that sort of thing. Not that you're going to treat them differently but for me it was just useful erm -*

## Appendix E.5 Emotional Responses

Emotional Responses	Related Themes	Focus Group
Dependency		
	Liaison with carers – psychosocial assessment	1 & 2
	Aftercare planning- Carers needs	1
	Emotional responses	1
	Making sense of self-harm- mental illness	2
	Patients as carers	2
	Aftercare Planning- Treatment criteria	2
	Making sense of suicidal ideation- mental illness	2
	Psychosocial Assessment- Support for carers	1
	Response to Vignette	1
Fight		
	Aftercare planning- voluntary services	1
	Aftercare planning- mental health services	1
	Mental health assessment- psychosocial history	1
	Psychosocial assessment- Liaison with carers	1
	Support for carers	1
	Patients as carers	2
Counter-dependency		
	Psychosocial assessments-constraints	2
	Patients as carers	2
	Aftercare planning- Patients' participation	2
	Response to Vignette	1
Flight		
	Attitudes- Coercive	1
Flight-pairing		
	Response to Vignette	1 & 2
Pairing		
	Response to Vignette	1
	Psychosocial assessment- Liaison with carers	1
	Mental health assessment-psychosocial history	1
	Mental health assessment- self-harm	1 & 2
	Aftercare plan- voluntary services	1
	Carers- Support	1
	Aftercare planning- achievable plan1	
	Emotional Responses	1 & 2
	Patients as carers	2
	Aftercare plan- balance risks and protective factors	2
	Making sense of SI- avoidance	2
	Aftercare plan- patients' participation	2
	Response to Vignette	2
	Aftercare plan- Turning points	2
Counter-pairing		
	Emotional responses	1 & 2

